

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Page 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Jack</b> <b>B.</b> <b>Nance</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR <b>3 A</b> M	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>9-12-1905</b>		6. AGE (In years last birthday) <b>63</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Fort Worth, Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7733 Greenview Terrace</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov. tBalCo.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>Oran</b> Middle <b>H.</b> Last <b>Nance</b>		15. MOTHER'S MAIDEN NAME First <b>Dora</b> Middle <b>Brown</b> Last <b>Terrace</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO. <b>703-12-1447</b>	
17. INFORMANT Address <b>Mrs. Helen T. Nance 7733 Greenview</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 HOUR</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 14, 1963</b> to <b>Dec. 18, 1968</b> , that (I) <del>was</del> saw the deceased alive on <b>DEC 5</b> 1968, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(didn't)</del> view the body after death.							
22b. SIGNATURE <b>T. C. Siwinski</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Dec. 19, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Thaddeus C. Siwinski</b>				22e. ADDRESS <b>206 W. Pennsylvania Avenue</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-20-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b>				ADDRESS <b>21212 4905 York Rd. Balto., Md.</b>		25a. RECEIVED BY <b>DEC 20 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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MADE IN AUSTRIA

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Handwritten signature or text at the bottom left corner.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)										2a. DATE KNOWN OF ESTI- DEATH MATED				2b. HOUR					
First Middle Last <b>DANIEL THOMAS NOLAN</b>										<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>XX 12 31 1968</b>				<b>? M</b>					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR			
Male		White		APRIL 21 1928		21 RS.						February 9 1969				4:50p			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				Md.			
UPPER MARYLAND				U.S.A.								Balto.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY							
Essex				near the Back River Neck Bridge															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
N.J.								Margate						306 N. Hardin Ave.					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last															
THOMAS F. NOLAN				Betty Jo Perry															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT							
Yes								455-70 4048				BETTY JO PERRY				Navy Record			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Presumably drowned																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. ? ? 19 ?						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Presumably drowned							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Water						21f. LOCATION Street or R.F.D. No. City or Town County State near Back River Neck Bridge Essex, Balto. Md							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)						Edward F. Wilson, M.D.						22b. DATE SIGNED 2/10/69							
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE 13 Feb 1969						23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial							
												23d. LOCATION (City or Town) (County) (State) Somerton PA							
24. FUNERAL DIRECTOR						321 Columbia St Howard Co. (funeral home)						25a. RECD BY REGISTRAR H. Walsh							
												25b. REGISTRAR'S SIGNATURE Charles Judge							
												DATE FEB 13 1969							

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VR 400 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>Eva B. Noratel</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>3</b> Year <b>1968</b>			2b. HOUR M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10/31/45</b>		6. AGE (in years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Lansdowne</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>215 First Ave</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Care Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1946 Sponson St.</b>	
14. FATHER'S NAME First <b>Harry</b> Middle <b>Sybock</b> Last			15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-28-6362</b>		17. INFORMANT <b>Beatrice Miller</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the pancreas</b> <b>157.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>157x</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>November 10, 1968</b> , to <b>December 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>November 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Morris W. Steinberg</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/3/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Morris W. Steinberg</b>				22e. ADDRESS <b>3913 Hollins Ferry Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Ambrase Inc. 1328 Sulphur Sq. Rd</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17164

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17174

1. DECEASED-NAME (Type or print) <b>Francis</b>			First Middle Last <b>Norton</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR <b>12:30</b> PM			
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>June 28, 1879</b>			6. AGE (In years last birthday) <b>89</b> YRS.			
7a. BIRTHPLACE (State or foreign country) <b>New York</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore,</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Paper Mill Manager (Ret.)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mfg.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Lutherville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET AND NUMBER <b>216 Felton Rd.</b>			14. FATHER'S NAME First Middle Last <b>James Norton</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ellen Clark</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>073-10-2699 A</b>			17. INFORMANT <b>Mrs. Mary Harrington</b>			Address <b>216 Felton Road Lutherville, Md. 21093</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <b>A</b> (this hospital) attended the deceased from <b>12/27/</b> , 19 <b>68</b> , to <b>12/27/</b> , 19 <b>68</b> , that <b>A</b> (we) last saw the deceased alive on <b>12/27/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Scilling</b>			DEGREE <b>Dr. Ines Cillani, M.D.</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12/27/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. Ines Cillani, M.D.</b>			22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12-30-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Balt. Maryland</b>			
24. FUNERAL DIRECTOR <b>Raymond J. Curran</b>			ADDRESS <b>817 Scarlett Dr. Towson, Maryland 21204</b>			25a. REC'D BY REGISTRAR <b>DEC 30 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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17165										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17175									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										Hour									
EARL FLOYD OATES										Dec. 11 1968										5:30 P.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
male			white			Sept. 8 1897			71 YRS.			MONTHS			DAYS			HOURS			MIN.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Va.			U.S.A.						Baltimore										Md.										
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Baltimore 7, Md.					5517 Forest Park Ave					carpenter																			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
Md.					Baltimore					Balto. 7					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					5517 Forest Park Ave									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
Jean Oates					Anna Lee Gardner																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT																			
no					213 01 4937					5517 Forest Park Ave, Mrs Loretta Isham Baltimore, 7, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>																													
1550 DUE TO, OR AS A CONSEQUENCE OF																													
(b) <u>Metastatic Carcinomatosis</u>															2 Months														
DUE TO, OR AS A CONSEQUENCE OF																													
(c) <u>Hepatoma</u>															4 Months														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
<u>Chronic Emphysema, ASCVD</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					Street or R.F.D. No. City or Town County State														
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-2</u> , 19 <u>60</u> , to <u>12-11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE					DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED														
<u>Peter V. Thack</u> MD															12-13-68														
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS																								
21 S. ST. JOHNS LANE					ELICOTT CITY - MD																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
burial					12/14/68					Meadowridge					Elkridge Howard Md.														
24. FUNERAL DIRECTOR					ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
<u>Higginbottom Stack Funeral Home</u>					<u>Ellicott City Md.</u>					DATE <u>DEC 17 1968</u>					<u>Charles Judge</u>														





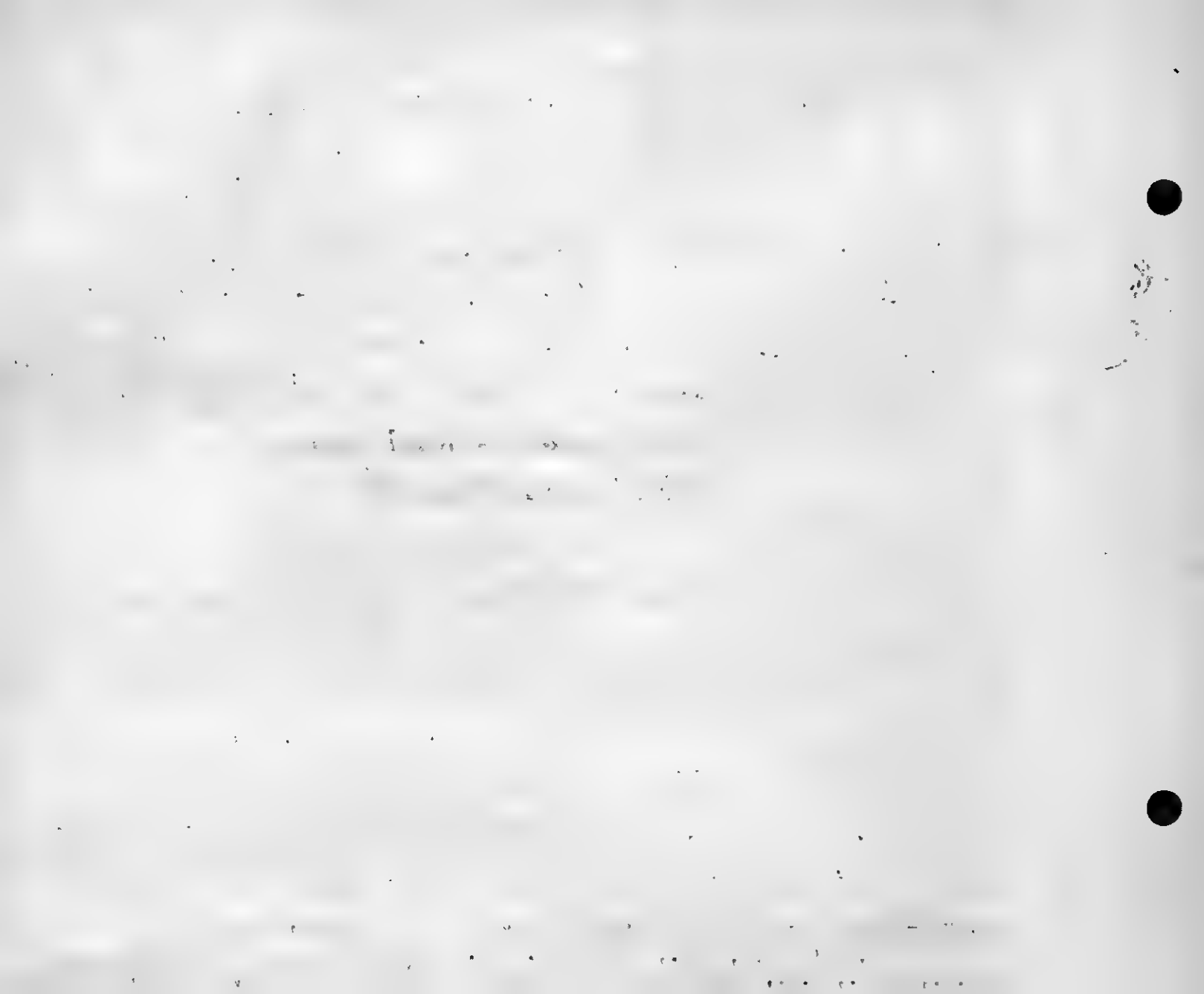
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>Mary F. Smith Oberholser</b>			2a. DATE OF DEATH Month Day Year <b>Dec 14 1968</b>			2b. HOUR <b>3:15 P.M.</b>	
3 SEX <b>F</b>		4. RACE <b>W</b>		5 DATE OF BIRTH <b>July 31, 1880</b>		6 AGE (in years last birthday) <b>88</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>W. Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sheppard Pratt Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Ohio</b>		13b. COUNTY <b>Cleveland Hts</b>		13c. CITY OR TOWN <b>Cleveland Hts</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>2933 Berkshire Rd.</b>		14. FATHER'S NAME First Middle Last <b>Arthur Bowman Smith</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Anne Gordon</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>286-44-8616</b>		17 INFORMANT <b>Hosp. Record Libr., Wash. D.C.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4129 Arteriosclerosis heart disease</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of breast</b>		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic Brain Syndrome &amp; Psychosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 9, 1964</b> to <b>Dec 14, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 14, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W.W. Elgin, M.D.</b>		DEGREE <b>W. W. Elgin</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/14/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>W. W. Elgin</b>		22e. ADDRESS <b>Sheppard Pratt Hosp. Towson Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>		23b. DATE <b>12-16-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glendale Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Akron, Ohio</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.,</b>		ADDRESS <b>5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 18-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) <i>Albert</i>		First <i>Albert</i>		Middle <i>Clayton</i>		Last <i>JR</i>		2a. DATE KNOWN OF DEATH EST <input checked="" type="checkbox"/> Month <i>Dec</i> Day <i>21</i> Year <i>1968</i>	
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>Sept 24 1919</i>	6 AGE (in years last birthday) <i>49 YRS</i>	IF UNDER 1 YEAR MONTHS <i>5</i> DAYS <i>1</i>	IF UNDER 24 HRS HOURS <i>1</i> MIN. <i>00</i>	2c. DATE PRONOUNCED DEAD Month <i>12</i> Day <i>21</i> Year <i>1968</i>		2b. HOUR <i>28</i> M <i>28</i> M	
7a. BIRTHPLACE (State or foreign country) <i>Ind</i>		7b. CITIZEN OF WHAT COUNTRY <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Balto</i>		Md	
10. CITY OR TOWN OF DEATH <i>Balto</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3825 Willoughby, Baltimore</i>				12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <i>Contract</i>	
13a. USUAL RESIDENCE (Where deceased lived if institution) STATE <i>Md</i>		13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Balto</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>3825 Willoughby Rd</i>	
14. FATHER'S NAME <i>Albert</i>		First <i>Albert</i>		Middle <i>Clayton</i>		Last <i>JR</i>		15. MOTHER'S MAIDEN NAME <i>Margaret</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16b. SOCIAL SECURITY NO <i>212-16-2579</i>		17. INFORMANT <i>Margaret Cling</i>		ADDRESS <i>3825 Willoughby</i>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ventricular Tachycardia</i> DUE TO, OR AS A CONSEQUENCE OF <i>Myocardial Infarction old - 8 to 10 yrs.</i> (b) <i>Chronic Coronary Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Cardiovascular Disease</i> (c) <i>Recent bout of Influenza</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>75 Min</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Recent bout of Influenza</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Frank J. Lastik</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>12/21/68</i>	
EXAMINER'S NAME (Type) <i>F.T. LASTIK JR</i>		M.D. <i>MD</i>		ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVA. (Specify) <i>Burial</i>		23b. DATE <i>12/24/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>				ADDRESS <i>3331 Brehms Lane</i>		25a. REC'D BY REGISTRAR <i>DEC 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



CERTIFICATE OF DEATH

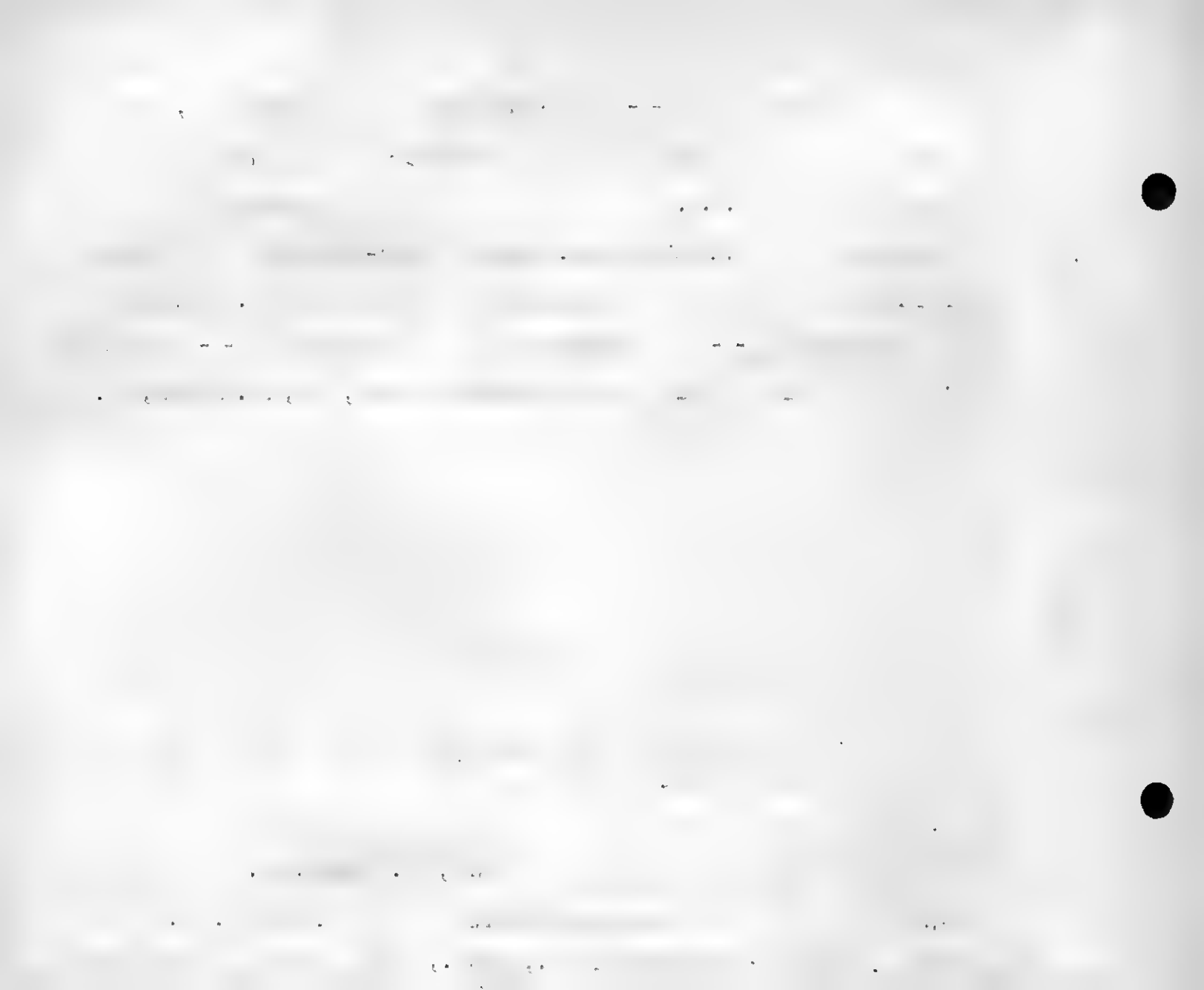
17168

17178

1 DECEASED NAME (Type or print) <b>ERNEST</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>DECEMBER 30, 1968</b>			2d. HOUR <b>9:00p</b>		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>10/16/94</b>			6. AGE (In years last birthday) <b>74</b> YRS		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>		
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMIN. HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>SELF-EMPLOYED</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>		
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <b>BERNARD</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>REGINA</b>			First Middle Last <b>SIEDLE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WWI</b>			17. INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>791X</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE, OLD AND RECENT</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>DEC 30, 1968</b> to <b>DEC 30, 1968</b> , that <del>he</del> (we) last saw the deceased alive on <b>DEC 30, 1968</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>Jan Anni Orer M.D.</b>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12/31/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>INFAN A. ORER, M. D.</b>						22e. ADDRESS <b>VAH, FT. HOWARD, MD.</b>					
23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>1-2-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>PARK WOOD CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>		
24. FUNERAL DIRECTOR <b>George L. Schwab</b>						ADDRESS <b>2101 Frederick Ave., Balto. Md.</b>			25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>		
									25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

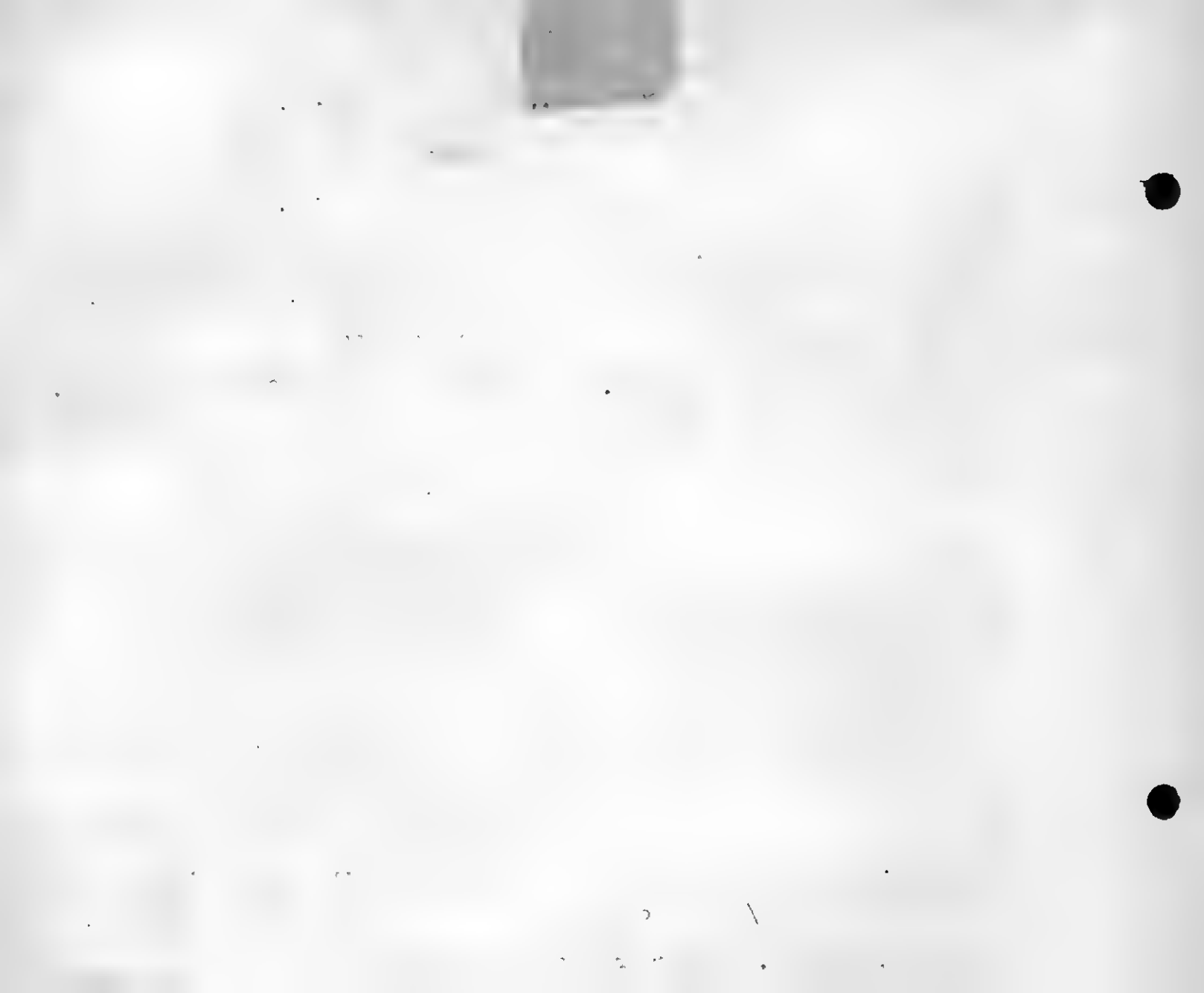




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>Items 1, 16 &amp; 17 Filled by</div> <div>1/3/69 kk 17169</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17179</div> <div>CERTIFICATE OF DEATH</div>													
1. DECEASED-NAME (Type or print) <b>MARIE</b> First <b>Emelia</b> Middle <b>MA/MA/MA/</b> Last <b>OLDEWURTEL</b>						2a. DATE OF DEATH <b>December</b> Month <b>29</b> Day <b>1968</b> Year			2b. HOUR <b>2:30</b>				
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>11-3-1890</b>			6. AGE (In years last birthday) <b>78</b> YRS.		7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. UNDER 24 HRS. HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md						
D. CITY OR TOWN OF DEATH <b>Towson</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>				12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. US. AT RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b></b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6026 Loch Raven Blvd.</b>			
14. FATHER'S NAME First <b>Henry</b> Middle <b>Oldewurtel</b> Last <b></b>						15. MOTHER'S MAIDEN NAME First <b>Ursula</b> Middle <b>Hatzold</b> Last <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>Unk. 217-32-5049</b>		17. INFORMANT <b>Albert</b> Address <b>Alberta Oldewurtel 6026 Loch Raven Blvd.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <b>Cerebral vascular episode-probably thrombosis</b>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <b></b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (I) (we) (did) (did not) attend the deceased from <b>12-1-1968</b> to <b>12-29-1968</b> , that (I) (we) last saw the deceased alive on <b>12-29-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Yefen G. Quintiquit</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>12-29-68</b>							
22d. PHYSICIAN'S NAME (Type) <b>Dr. Elfred Quintiquit</b>						22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a. BURIAL, CREMATION, (Specify) <b>Burial</b>		23b. DATE <b>1/2/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b> ADDRESS						25a. REC'D BY REGISTRAR <b>DEC 30 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17170 CERTIFICATE OF DEATH 17180											
1 DECEASED NAME (Type or print)		First <b>Delilah</b>		Middle <b>J</b>		Last <b>Osborne</b>		2a DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>68</b>		2b HOUR <b>8:30</b> A.M.	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>July 22, 1900</b>			6 AGE (In years last birthday) <b>68</b> YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore,</b>			Md		
10 CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>				12a USJA OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a USJA RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>		13b COUNTY <b>N</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>5514 Sagra Rd., #12</b>			
14 FATHER'S NAME First <b>William</b> Middle <b>H. Miller</b> Last		15 MOTHER'S MAIDEN NAME First <b>Lizetta</b> Middle <b>Baublitz</b> Last									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b SOCIAL SECURITY NO. <b>061 09 6872</b>		17 INFORMANT Address <b>Charles C. Hahn 5514 Sagra Rd.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia, Left Lung.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)				21f LOCATION Street or R.F.D. No.		City or Town		County	State
22a I certify that (X) (this hospital) attended the deceased from <b>11-20-</b> , 19 <b>68</b> , to <b>12-9-</b> , 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>12-9-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (Y) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Christina Feliciano</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED <b>12-9-1968</b>					
22d PHYSICIAN'S NAME (Type) <b>Christina Feliciano, M.D.</b>		22e ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>12/12/1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Miller EUB Cemetery</b>			23d LOCATION (City or Town)		(County)	(State)	
24. FUNERAL DIRECTOR <b>Mitchell Wiedefeld</b>		ADDRESS <b>Home 6500 York Rd.</b>				25a REC'D BY REGISTRAR <b>DEC 13 1968</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17171										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17181									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Pearl Newell Osgood										Dec 6 1968										M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Female			White			1-1-1882			86 YRS			MONTHS DAYS			HOURS MIN														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Monte Video, Dakota			USA						Baltimore Md.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY																				
Baltimore			7303 Brompton Road			At Home																							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER																	
Md.			Baltimore			Balto			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7303 Brompton Rd. #7																	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
James B. Newell					Unknown																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
NO					NONE					James Osgood-7303 Brompton Road #7																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ATHEROSCLEROTIC HEART DISEASE</u>															7 years														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY SCLEROSIS</u>															8 YEARS														
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
NONE																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
NONE										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																													
22a. I certify that (I) (this hospital) attended the deceased from <u>5-12</u> , 19 <u>55</u> , to <u>12-6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
Ray Oshman M.D.										12-6-68																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
										5907 GWYNN OAK AVE. BALTO. MD																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12-9-68					Woodlawn Cemetery					Baltimore, Maryland														
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
Ellsworth Armacost-4600 Liberty Hghts. Ave.										DATE DEC 12 1968					J. Charles Judge														





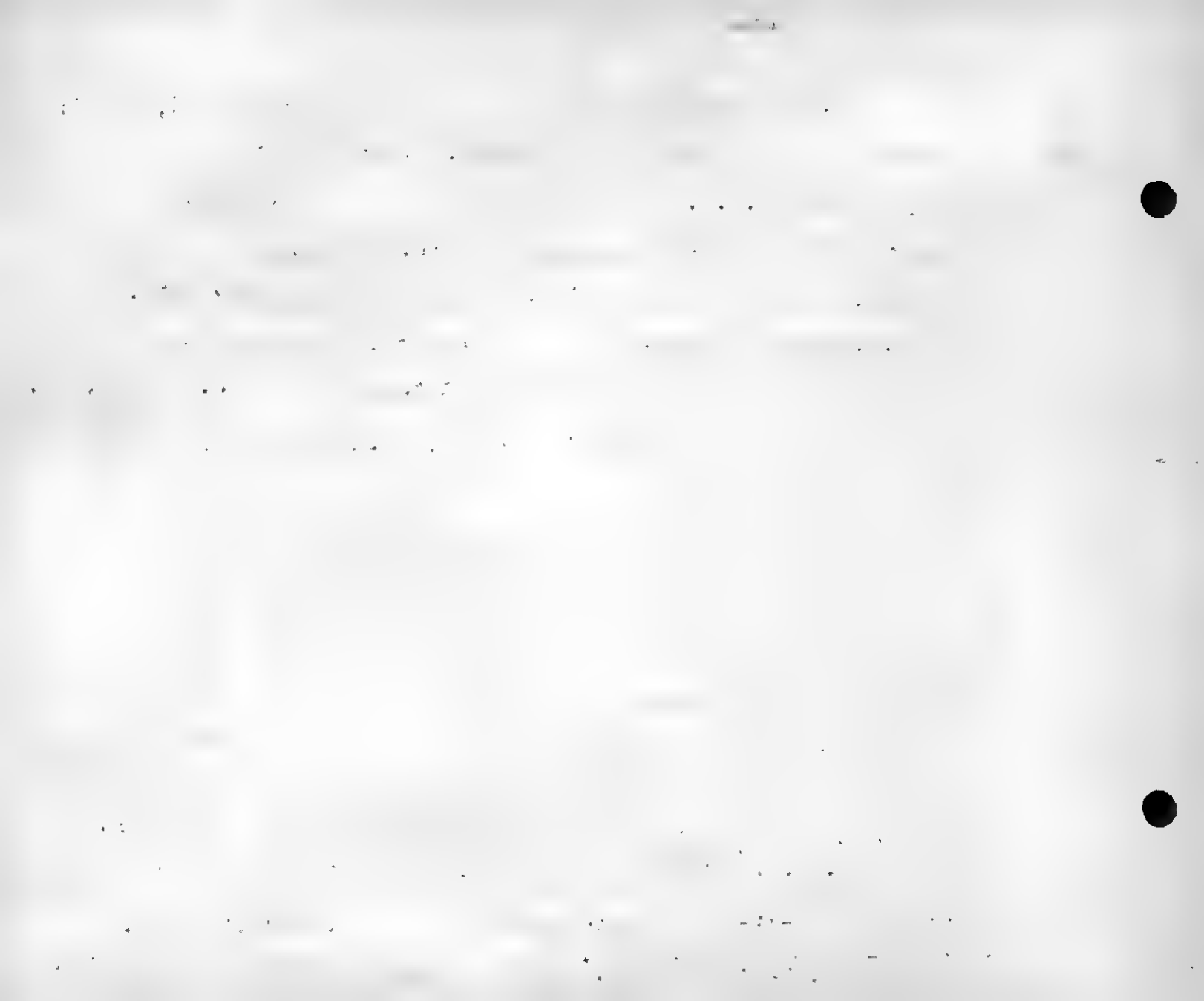
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and 3 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Maude Leizure Owrey</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1968</b>			2b. HOUR <b>5:30</b> MIN <b>M</b>							
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 3, 1883</b>		6. AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.							
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Presbyterian Home of Md.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>Northway Apts.</b>	
14. FATHER'S NAME First <b>Enoch Hughes</b> Middle <b>Leizure</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Margaret Elizabeth</b> Middle <b>Lea</b> Last <b></b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <b></b>		17. INFORMANT Address <b>Presbyterian Home of Md. Towson, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC C.V. DISEASE</b> <b>41 -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>4 - Nephrosclerosis</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 1, 1964</b> to <b>DEC 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>DEC. 18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Dr. S.J. Venable</b>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>12-23-68</b>						
22d. PHYSICIAN'S NAME (Type) <b>Dr. S.J. Venable</b>					22e. ADDRESS <b>7215 York Rd. Baltimore, MD</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12-24-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>			23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Md.</b>						
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>					ADDRESS <b>6500 York Rd. Baltimore, Md. 21212</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, bagged, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17173		CERTIFICATE OF DEATH						17183			
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR A		
William			PALLME			Month 12 Day 22 Year 68			5:00 M		
3. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		6/12/68			YRS. 6 MONTHS 10 DAYS		IF UNDER 24 HRS. MIN.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md	
Virginia		U.S.A.					Baltimore				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Owings Mills,			Rosewood State Hospital			Dependent			none		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Montgomery			Cabin John			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
First Middle Last			First Middle Last			6508 81st St.,					
Robert Crosett PALLME			Kari Ruth KRISTOFFERSEN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address		
no			----			Rosewood Records, Owings Mills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>INTER-VENTION Hydrocephalus &amp; tumor</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <i>Increasing myelocoele</i>										Congenital	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <i>meningoencephalitis</i>										5 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<i>institutionalized since birth</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
			HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Nat. while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 10/23/68, 19 to 12/22, 1968, that (I) (we) (we) saw the deceased alive on 12/22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death											
22b SIGNATURE			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED		
<i>Richard A. Jones</i>									12-2368		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Richard A. Jones, M.D.			Rosewood State Hosp.								
23a. BURIAL (CREMATION, REMOVAL) (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
12-26-68			12-26-68			Fletcher Cemetery			Chesapeake Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
W. W. Chambers, Co., Inc.			WASH. D.C.			DATE DEC 31 1968			<i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~attach~~ <sup>attach</sup> carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17174		GLADYS		N.M.I.		CERTIFICATE OF DEATH		17184	
1. DECEASED NAME (Type or print) First Middle Last GLADYS NMI PALMER		2a. DATE OF DEATH Month Day Year 12 15 68				2b. HOUR 3:20 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12.17.98		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) ROME N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTIMORE COUNTY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) H.W.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6800 LIBERTY RD.	
14. FATHER'S NAME First Middle Last Thomas MARSH		15. MOTHER'S MAIDEN NAME First Middle Last Carmie Gilly		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) NO		16b. SOCIAL SECURITY NO 135-38-2612		17. INFORMANT JOHN PALMER	
16c. ADDRESS 6800 LIBERTY RD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Emboli (b) Old and Fresh Thrombophlebitis (c) C.A. of Uterus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instantaneous 2 months 1 1/2 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1 year old Hysterectomy - Rodium Implantation									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-13-1968, to 12-15-1968, that (I) (we) last saw the deceased alive on 12-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Cesar Valle Cervero		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-15-68					
22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO		22e. ADDRESS 8629 Liberty Rd							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-19-68		23c. NAME OF CEMETERY OR CREMATORY St. Gertrude		23d. LOCATION (City or Town) (County) (State) Woodbridge N.J.			
24. FUNERAL DIRECTOR LONN & BYERS		ADDRESS 8728 LIBERTY RD.		25a. REC'D BY REGISTRAR DATE DEC 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

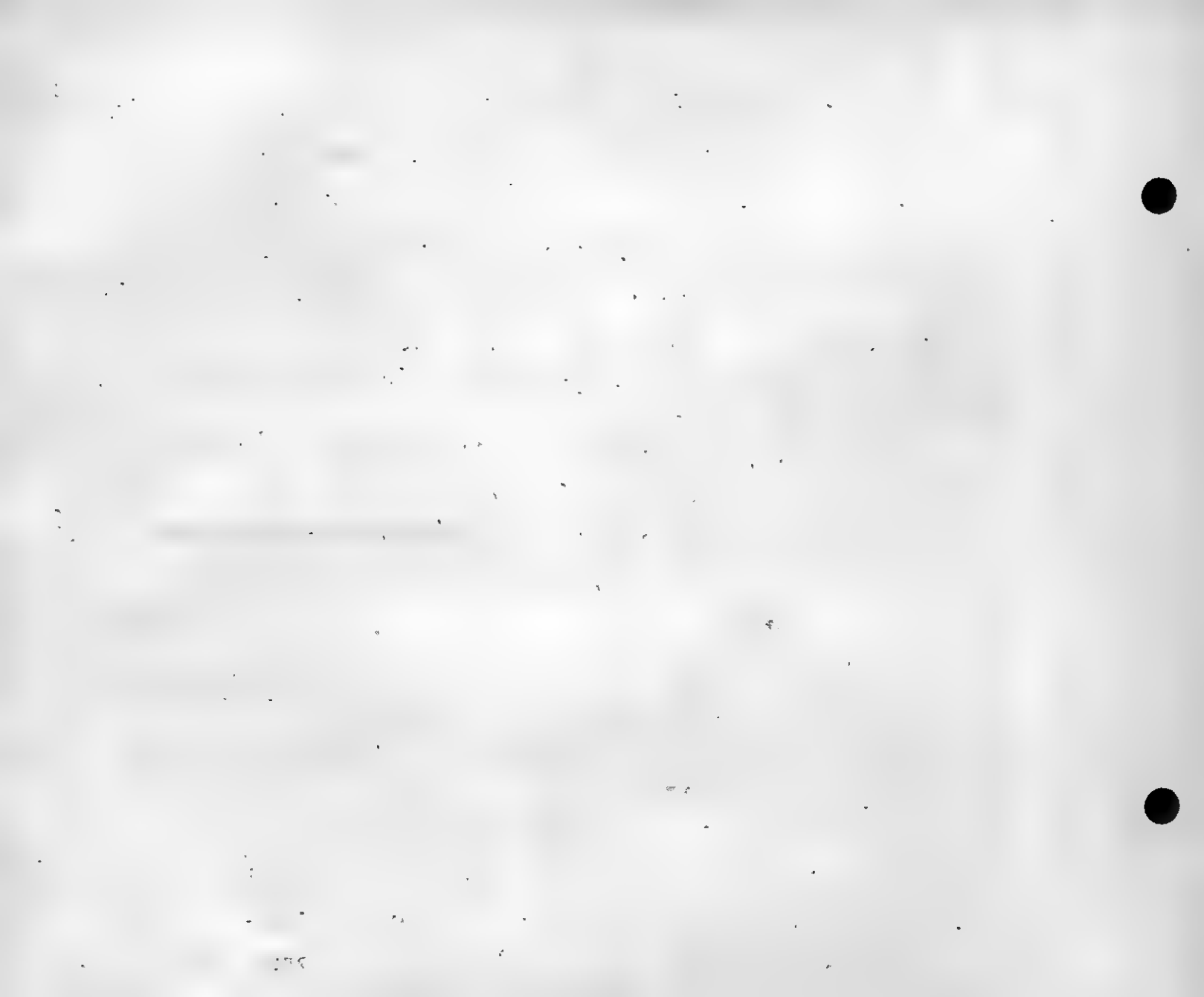




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17175 CERTIFICATE OF DEATH 17185									
1 DECEASED NAME (Type or print) <b>RUDOLPH FRANK PARIZEK</b>			First Middle Last			2a DATE OF DEATH Month <b>DEC.</b> Day <b>27</b> Year <b>1968</b>			2b HOUR <b>3 P.M.</b>
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JULY 2, 1920</b>		6 AGE (In years last birthday) <b>48</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>8236 NORTHVIEW RD</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PRINTING</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PRINTER</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c CITY OR TOWN <b>BALTO.</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>Bon Air Press 8236 NORTHVIEW RD.</b>	
14. FATHER'S NAME <b>RUDOLPH PARIZEK</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>BERTHA SLAVNIK</b>			First Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-16-3557</b>		17 INFORMANT Address <b>MARY E. PARIZEK 8236 NORTHVIEW RD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARCINOMA of CARDIAC PORTION</b> <b>1510</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>of Stomach + Lower end of</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Esophagus C. Generalized Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>1510</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>150X No No</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>35 Mos</b>
19a. DATE OF OPERATION <b>JAN. 1966</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>#18</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>11:00 AM Jan 19 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>none</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <b>none</b>		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov - 1919</b> , to <b>Aug 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 25 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M.B. Davis</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <b>MELVIN B. DAVIS M.D.</b>		22e. ADDRESS <b>6800 MORNINGTON RD. DUNDALK MD 21222</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/31/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR <b>SCHIMUNEK FUNERAL HOME</b>		ADDRESS <b>3331 BREHMS LA. BALTO. MD</b>		25a. REGD. BY REGISTRAR DATE <b>JAN 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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117

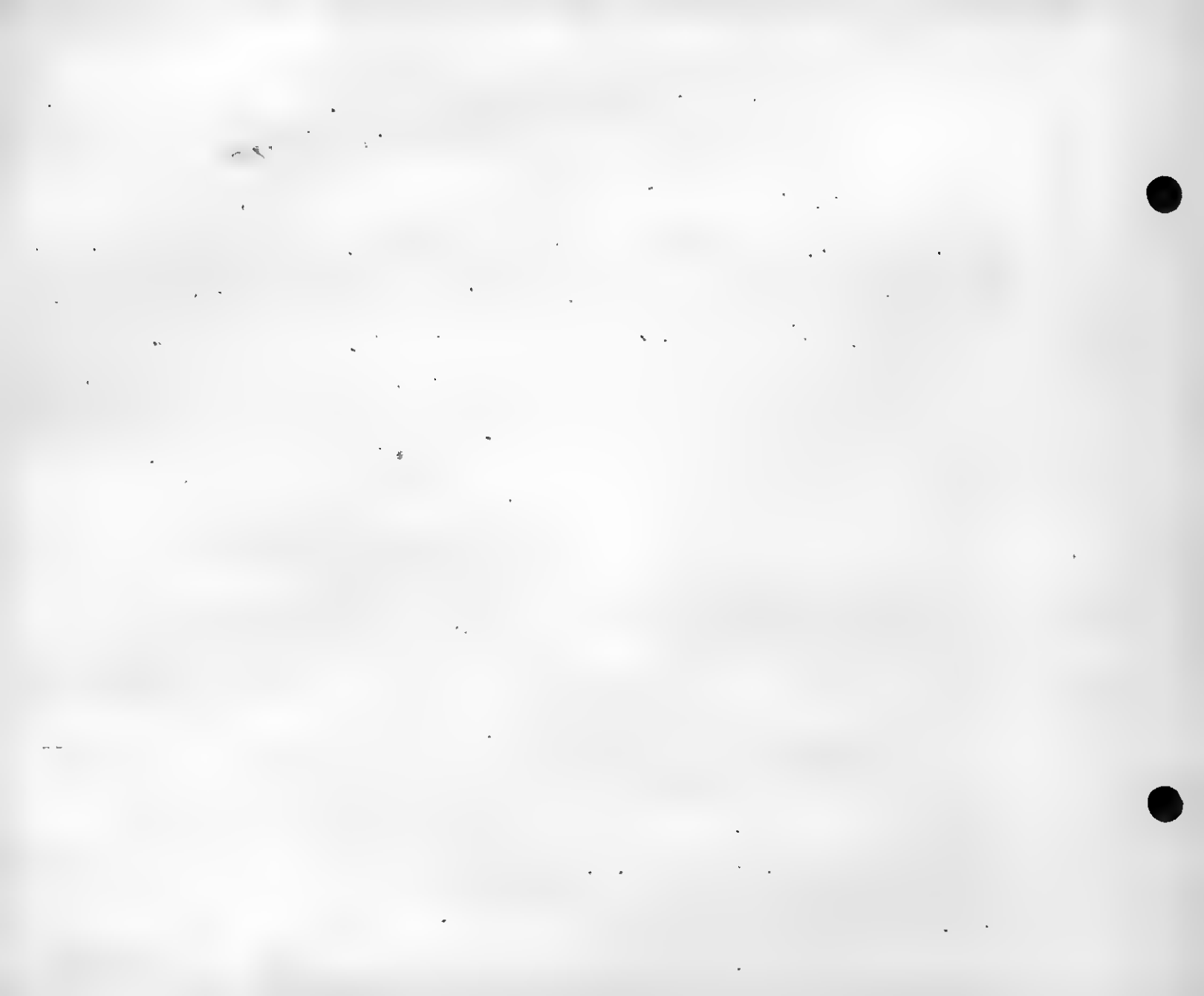
17178

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17186

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>NELSON NMN PARKER</b>			2a. DATE OF DEATH 12 Month 30 Day 68 Year		2b. HOURa 10:15 M
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MAR 26 1895		6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.	
10. CITY OR TOWN OF DEATH Baltimore, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MOLASSES IND. (RETIRED)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY —	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1013 S. SHARP ST.	
14. FATHER'S NAME First Middle Last NELSON PARKER		15. MOTHER'S MAIDEN NAME First Middle Last IRENE RASCOE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address JAMES F. PARKER 4615 PIMICO Rd. (15)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of lung</u> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/26, 19 68, to 12/30, 19 68, that (I) (we) last saw the deceased alive on 12/30, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John E. Adams, M.D.		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/30/68	
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.		22e. ADDRESS Greater Baltimore Medical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-4-69	23c. NAME OF CEMETERY OR CREMATORY MOUNT CALVARY		23d. LOCATION (City or Town) (County) (State) ARLUNDEN CO. Md.	
24. FUNERAL DIRECTOR I.L. BROWN & SON		ADDRESS 123 W. MONTGOMERY ST.		25a. REC'D BY REGISTRAR DATE JAN 6 1969	
				25b. REGISTRAR'S SIGNATURE Charles J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <b>ELVID</b>			First Middle Last <b>- - PARRY</b>			2a. DATE OF DEATH Month Day Year <b>DECEMBER 31, 1968</b>		2b. HOUR <b>8:00p M</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>5/4/19</b>		6 AGE (In years last birthday) <b>49</b> YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>BALTIMORE</b>		Md.	
10 CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMIN. HOSPITAL</b>		12a. USJA. OCCUPATION (kind of work done during most of working life, even if retired) <b>PAY CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>BOX 574</b>	
14 FATHER'S NAME First Middle Last <b>OWEN - - PARRY</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>MYFANYWY - - JONES</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO <b>1954 TO 1960</b>		17 INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>									
2410 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <b>DELERIUM TREMENS</b>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<b>307XCTIRRHOSIS OF LIVER, YEARS</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P M 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DEC 27, 1968</b> , to <b>DEC 31, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DEC 31, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE <b>Wm Arni Orer M.D.</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/2/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>INFAN A. ORER, M. D.</b>				22e. ADDRESS <b>VAH, FT. HOWARD, MD.</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-8-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (County) (State) <b>BALTIMORE, MARYLAND D.C.</b>			
24. FUNERAL DIRECTOR <b>Wm M. Lyons</b>				ADDRESS <b>TAYLOR FUNERAL HOME</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17178										
17188										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
ELIZABETH MARIE PEARMAN						DEC. 12 1968		7:35 A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
FEMALE		White		July 3, 1914		54 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				BALTIMORE Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			GR. BALTO. MD. CENTER			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2637 Eastern Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Vincent Pagano			Elizabeth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
					Jeanna Reese 6223 Everall Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY @ CARDIAC FAILURE</b>										
DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMONIA FROM BREAST TO LUNGS, PERICARDIUM @ ESOPHAGES.</b>										
DUE TO, OR AS A CONSEQUENCE OF (c) <b>LUNGS, PERICARDIUM @ ESOPHAGES.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<b>170X PNEUMONIA</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State						
22a. I certify that (H) (this hospital) attended the deceased from <u>11/26/68</u> , 19 <u>68</u> , to <u>12/12/68</u> , 19 <u>68</u> , that (H) (we) lost the deceased alive on <u>12-12-68</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
B.R. Friedlander M.D.						12/12/68				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
B.R. FRIEDLANDER, M.D.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12-16-68		New Cathedral Cem.		Baltimore Md.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
B. Dabrowski 2818 E. Baltimore St.						DATE DEC 16 1968		Charles Judge		





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VR A15  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR
Ida			A.		Pensyl		Dec. 30 1968			11.30		
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Female			White			Sept. 30, 1906			362 YRS.			
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
MD.			United States						Balto. Co. Md.			
1d CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Towson, Md.			Dulaney-Towson Nursing Home			Seamstress						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER
Md			Balto.			Lutherville			NO			Muirfield Court, 21093
14. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last
Joseph			Karczeski		UNKNOWN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address			
NO			213-03-6905			N.H. Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED METASTATIC CANCER</u> <u>151,9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER OF STOMACH</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>151X</u>												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <u>9/25/68</u> , 19 <u>68</u> , to <u>12/30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/20/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												
22b SIGNATURE <u>T. C. Siwinski</u>			DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>12/31/68</u>			
22d. PHYSICIAN'S NAME (Type)			T. C. Siwinski, M.D.			22e. ADDRESS <u>206 W. Penna. Ave., Towson, Md. 21204</u>						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			12-1969		Loudon Park Cem.			Balto., Md.				
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson			1050 York Rd			JAN 3 1969			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The page remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

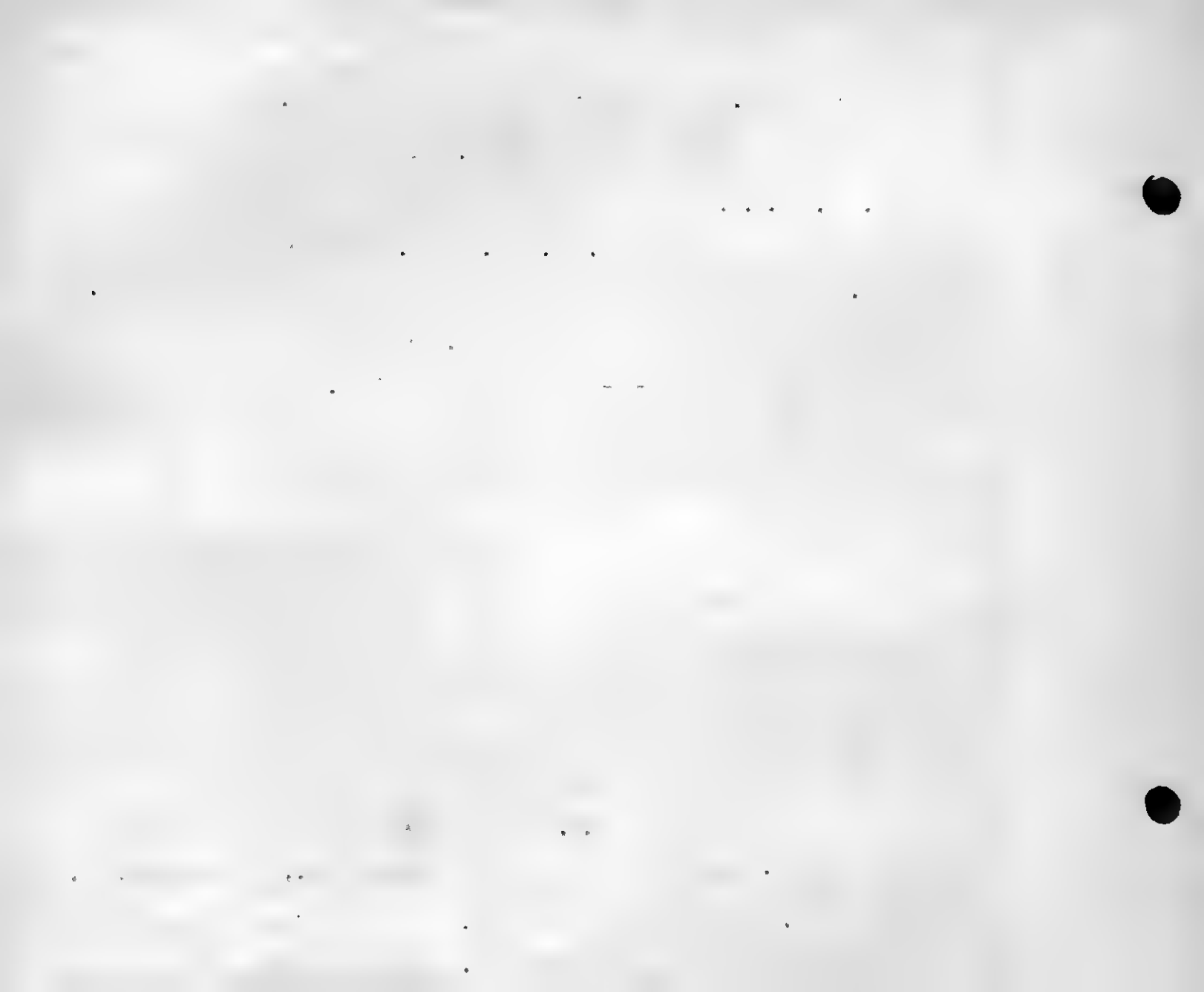
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
MARIE			IDA		PETERS		December 13, 1968		2b. HOUR 2:30 M		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS HOURS MIN		
Female		White		February 17, 1888			60 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Maryland		USA					Baltimore		Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			ST. JOSEPH HOSPITAL			retired checker			Laundry		
13a. US. AT RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore		Dundalk				113 Kinship Rd. 21222		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
William H. Peters			Margaret Schluter								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address 2202 Boxmore Rd. William H. Peters, Sr., Timonium, Md. 21093					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Occlusion left femoral artery; Pre-gangrenous left foot.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from <u>December 12, 1968</u> to <u>Dec. 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>Eduardo Montelibano, M.D.</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>12/13/68</u>		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Dec. 16, 1968			Mt. Carmel Cemetery			Baltimore, Md.		
24. FUNERAL DIRECTOR <u>Ollrich Funeral Home, Dundalk, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 20 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17191 CERTIFICATE OF DEATH 17191									
1. DECEASED-NAME (Type or print) Charles H. Pfau			First Middle Last			2a. DATE OF DEATH Dec. 26 25 Day 68 Year		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 28, 1914		6. AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3709 Downy Dale Dr.	
14. FATHER'S NAME First Middle Last Harry Christian Pfau			15. MOTHER'S M A DEN NAME First Middle Last Edna J. Krammer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If unknown) NO		16b. SOCIAL SECURITY NO 212-05-3791		17. INFORMANT Address Mrs. Virginia M. Pfau 3709 Downy Dale Drive 21133					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Myocardial infarction									
DUE TO, OR AS A CONSEQUENCE OF + subseq. pulmonary edema									
(b) ASCVD + Diabetes									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Past history of coronary several years									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 19 64 to Nov 19, 1968, that (I) (we) last saw the deceased alive on Nov 26, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John Darrell M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/26/68					
22d. PHYSICIAN'S NAME (Type) John J. Darrell		22e. ADDRESS 9017 Liberty Rd., Randallstown, Md.							
23a. BURIAL CREMATION, REMOVAL (Type) Burial		23b. DATE Dec. 28, 68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR Loring Byers Funeral Chapel 8728 Liberty Rd.				ADDRESS		25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



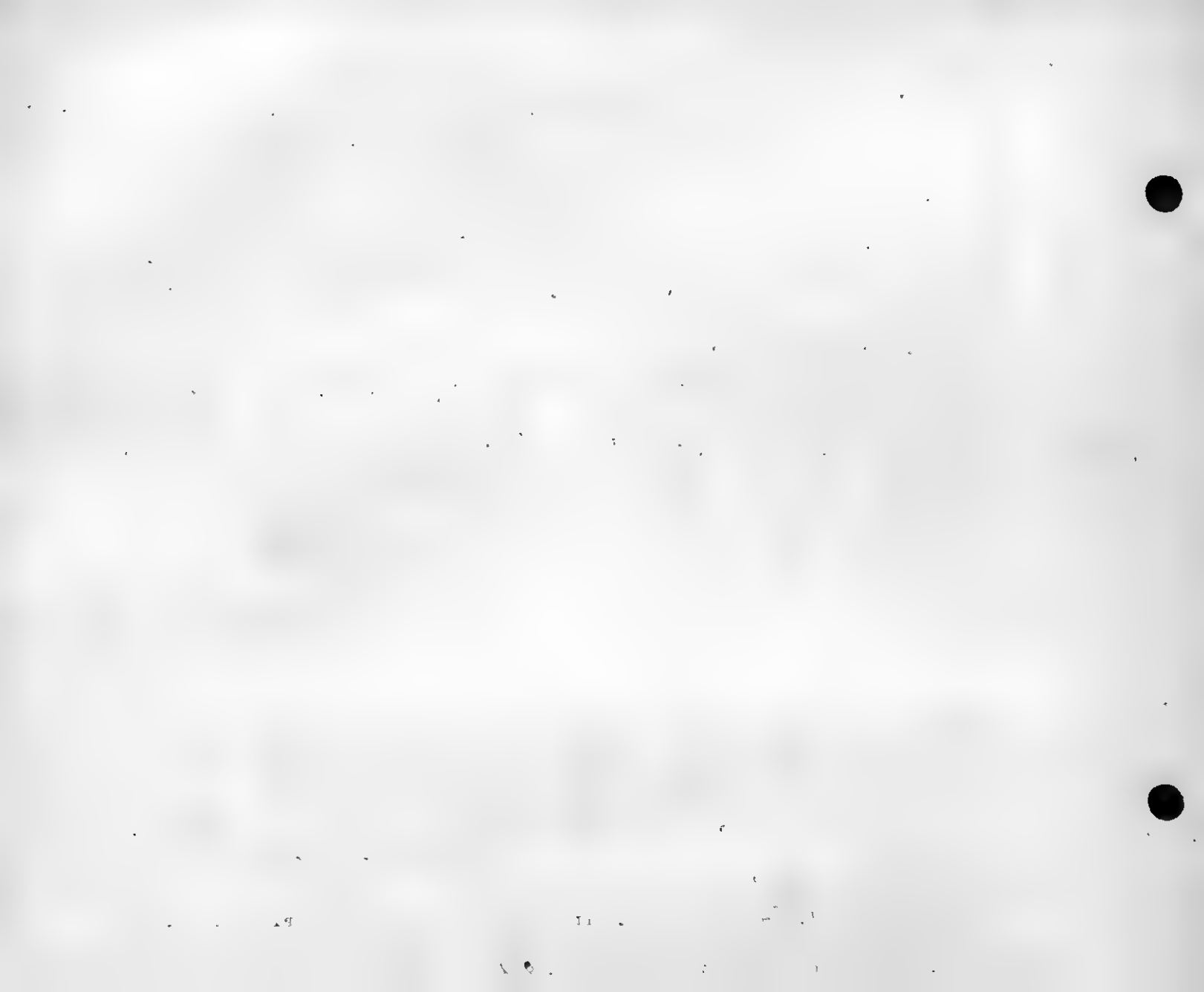
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print) <u>Frieda</u>			First <u>L.</u>		Middle <u>Pfeifer</u>		Last		20. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1968</u>		26. HOUR <u>5:35</u> AM				
3. SEX <u>Female</u>			4. RACE <u>White</u>			5. DATE OF BIRTH <u>Mar 21 1886</u>			6. AGE (in years last birthday) <u>82</u> YRS			IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>	
7a. BIRTHPLACE (State or foreign country) <u>Balto Md</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Baltimore</u> Md						
10. CITY OR TOWN OF DEATH <u>Towson</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Aged Women's + Aged men's Home</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY <u>Seamstress</u>						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md</u>			13b. COUNTY <u>Balto</u>			13c. CITY OR TOWN <u>Balto</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <u>2164 Hollins St</u>			
14. FATHER'S NAME <u>Gustav Herman Pfeifer</u>			First <u>Pfeifer</u>		Middle		Last		15. MOTHER'S MAIDEN NAME <u>Johanna W. Meier</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. <u>27-07-7002</u>			17. INFORMANT <u>Dorothy Denker</u>			Address <u>87615 Chestnut Ave</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial PNEUMONIA</u> <u>4431</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>yes?</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4. ....</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>63</u> , to <u>Dec 21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Merland E. Day</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>Dec 21, 1968</u>						
22d. PHYSICIAN'S NAME (Type) <u>Merland E. Day</u>			22e. ADDRESS <u>4-E-33 rd St Baltimore Md</u>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>12, 21-68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Western</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>						
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>						25a. REC'D BY REGISTRAR <u>DEC 24 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

MEDICAL CERTIFICATION





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

<div> <div>Item 2 Phoned N.H.1-8-5898</div> <div>17183</div> <div>17193</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>											
1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> ✓ COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>8 mo -</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 21230					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri La - H. Home.</u>						d. STREET ADDRESS <u>2801 Washington Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>WALTER PHELPS</u>						4 DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1968</u>					
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>May 10, 1878</u> 90 yrs		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months <u>25</u> Days <u>19</u> Hours <u>68</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocery store manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>grocery store manager</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Phelps</u>						14. MOTHER'S MAIDEN NAME <u>Eliza Jane De Graf</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>2 15-09-2638</u>		17. INFORMANT <u>Myrtle Phelps</u>		Address <u>2801 Washington Blvd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4127</u> DUE TO <u>atherosclerotic cardiac vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>15 yrs</u> DUE TO (c)											
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4127</u> <u>Diabetes Mellitus</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> pm				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>J. Nelson McKee, M.D.</u>				22. DATE SIGNED <u>12/25/68</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-28-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Ellicott City, Md</u>			
24. FUNERAL DIRECTOR <u>Donaldson Funeral Home, Baltimore, Md</u>						25a. REC'D BY REGISTRAR <u>DIAN 7</u>		25b. REGISTRAR'S SIGNATURE <u>Cherrie Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)  
304 REV 1-69

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
CHARLES			GAITHER		POWELL		December 29		1968		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR		
MALE		NEGRO		9-25-1895			73 YRS.		48 M		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Balto. Co., Md.			U.S.A.					Balto. Co. Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sparks, Md.			Ensor Mill Road			Retired			----		
13a. USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			13b. COUNTY			Sparks		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Ensor Mill Road	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
ROBERT			W.		POWELL				ANNIE VENNEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes.			214-22-8137A			Mrs. Marie Powell			Ensor Mill Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4379 <i>✓</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arterio Sclerosis</i>										3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										7 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21c. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1953, to Dec 1968, that (I) (we) last saw the deceased alive on 29 Dec 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			WALTER T. KEES MD				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)			WALTER T. KEES				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			1-2-69		Stevenson Church Cem.			Monkton, Maryland			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MORTON & DYETT F.H.						1701 Laurens St.		JAN 2 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 7a Film G107 12/16/68 17185										MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17185									
1. DECEASED NAME (Type or print) <b>HARVEY MARCELLUS POWERS</b>										2a. DATE OF DEATH 12 Month 02 Day 68 Year 2b. HOUR 10 P M									
3. SEX <b>MALE</b>			4. RACE <b>CAU</b>			5. DATE OF BIRTH <b>05-31-94</b>			6. AGE (In years lost birthday) <b>74</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md										
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GTR. BALTO. MED. CNTR</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY										
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>			13b. CITY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>COCKEYSVILLE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>BOXER HILL RD.</b>								
14. FATHER'S NAME First Middle Last <b>Marcellus J. Powers</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary S. Perkins</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>YES</b>			16b. SOCIAL SECURITY NO <b>113-10-0858</b>			17. INFORMANT <b>Family Records</b>							Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHI PNEUMONIA AND URINARY INFECTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRO VASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 DAYS</b>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>11-22-</b> 19 <b>68</b> , to <b>12-02</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>12-02</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <b>D. F. Naeim</b>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-02-68</b>							
22d. PHYSICIAN'S NAME (Type) <b>F. NAEIM</b>										22e. ADDRESS <b>6701 N. CHARLES STREET</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Dec. 5, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Grace-Falls Rd. Meth. Cem.</b>			23d. LOCATION (City or town) (County) (State) <b>Cockeysville, Md.</b>										
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>						ADDRESS		25a. RECD BY REGISTRAR DATE <b>DEC 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
Frank		Lester	Price Jr		Dec	Month 30	Year 68 4:55 PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Male	White		5-2-85		83 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Md.	U.S.				Baltimore County Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown		Baltimore County Gen Hosp					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.		Balto		Owings Mills		Garrison Forest Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Frank		Price		Gusty Raniker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> (If yes give war or dates of service)		6b. SOCIAL SECURITY NO.		17. INFORMANT Address			
		218-36-8306		Mr. William D. Groff Owings Mills, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HABED, old antero-septal myo-</u>							
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>cardiac Infarction</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>4201 Dehydration</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> 19 <u>68</u> , to <u>12-30</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12-30</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Gregory Pearson, MD</u>				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)	
				12-30-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Jan. 2, 68		Carrolls Chapel		Lutherville	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. F. Eline & Sons Reisterstown, Md.				JAN 3 1969		Charles Judge	



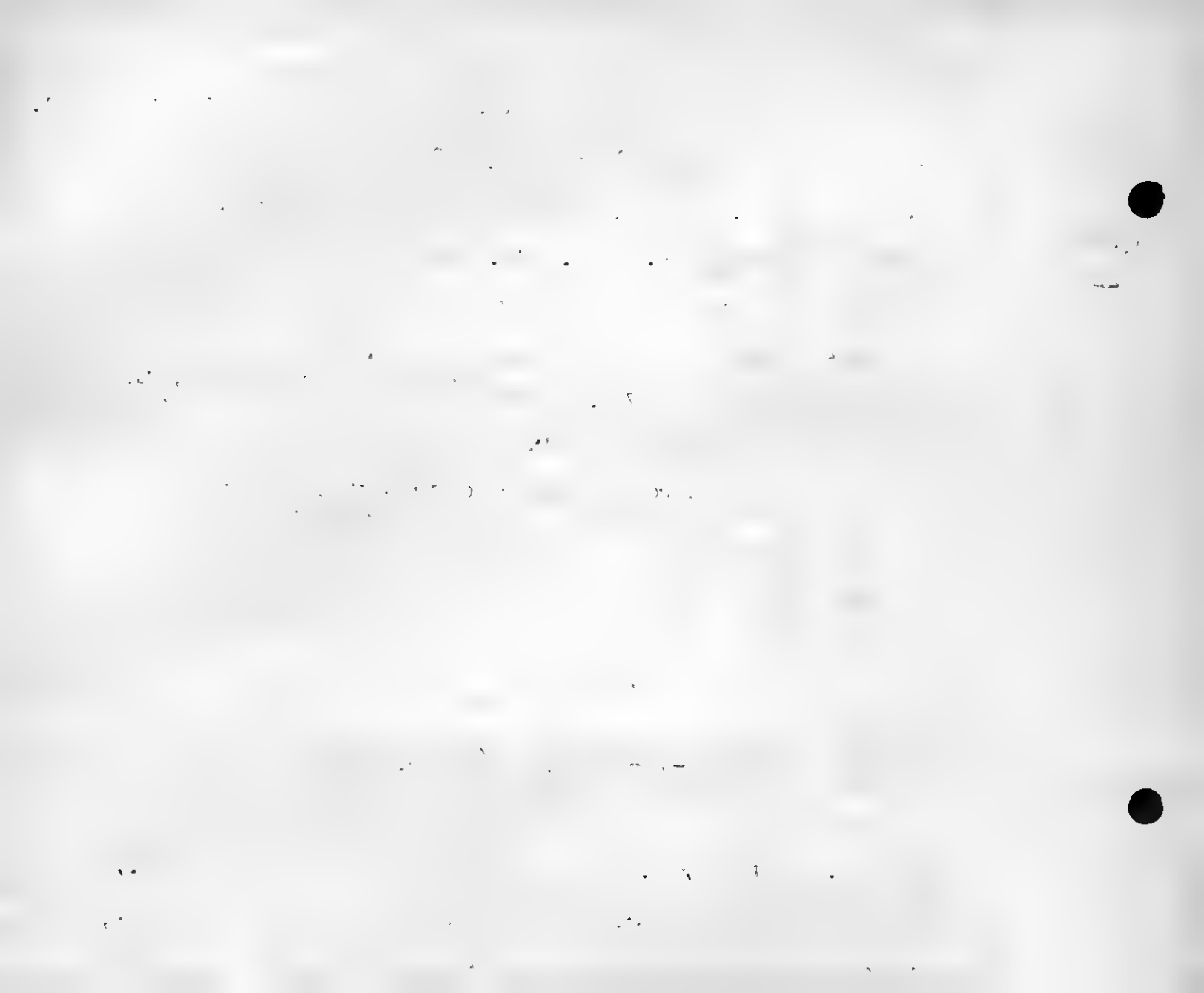


1-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>17187</div> <div>CERTIFICATE OF DEATH</div> <div>17197</div>									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
WILLIAM C PRICE						12 Month 18 Day 68 Year			10:05
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		CAUCASIAN		1-03-76		92 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Lutherville Md.		U.S.A.				BALTIMORE		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE			GREAT. BALT. MED. CENT						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
M.			Baltimore		Glencoe		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rural
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Ambrose			Elizabeth Burnham						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			217 03 3306		Emma Mosner Price, Glencoe, Md. 21152				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC URINARY OBSTRUCTION AND CYSTIC KIDNEYS</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> , 19 <u>68</u> , to <u>12/18</u> , 19 <u>68</u> , that (I) <del>(we)</del> lost the deceased alive on <u>12-18-68</u> 19 <u>68</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.									
22b. SIGNATURE <u>R. Vasudeva</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-18-68		
22d. PHYSICIAN'S NAME (Type) R. VASUDEVA, M.D.					22e. ADDRESS 6701 N CHARLES ST, BALT. MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-21-68		St. Johns Lutheran		Glencoe Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks Towson, Towson, Md. 21204					DEC 23 1968		<u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) <b>Paul</b>		First <b>GORDON</b>		Middle <b>PURCELL</b>		Last		2a DATE OF DEATH Month <b>DECEMBER</b> Day <b>29</b> Year <b>1968</b>			2b HOUR <b>4:45</b> M	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>10-27-99</b>				6 AGE (In years last birthday) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md						
10 CITY OR TOWN OF DEATH <b>Randallstown</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. Co. Gen. Hosp</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>Balto</b>		13c CITY OR TOWN <b>Edmondson Heights</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>1435 FOREST PK AVE</b>				
14 FATHER'S NAME First <b>ELGAR</b> Middle <b>PURCELL</b> Last		15 MOTHER'S M A DEN NAME First <b>CLARA</b> Middle <b>CRAMER</b> Last										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>214-03-7144</b>		17 INFORMANT <b>CHART</b> Address								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> (b) <b>Due to, or as a consequence of Duodenal obstruction and aspiration</b> (c) <b>Due to, or as a consequence of Carcinoma of pancreas with metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>157x Diabetes mellitus</b>												
19a DATE OF OPERATION <b>12-24-68</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>OBSTRUCTION 3rd PORTION</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State								
22a I certify that (I) (this hospital) attended the deceased from <b>12-14</b> , 19 <b>68</b> , to <b>12-29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-29</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <b>Jesus C. Santem</b> M.D. DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED <b>12-29-68</b>								
22b PHYSICIAN'S NAME (Type) <b>Jesus C. Santem</b>		22e ADDRESS <b>Baltimore County General Hospital</b>										
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>1-1-69</b>		23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore City, Balto. Md.</b>						
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Ave. 21229</b>				25a REC'D BY REGISTRAR <b>DEC 31 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
17189 CERTIFICATE OF DEATH 17199													
1. DECEASED NAME (Type or print)			First <b>LEE</b>			Middle <b>STEVEN</b>			Last <b>QUESENBERRY</b>				
3 SEX <b>MALE</b>			4 RACE <b>WHITE</b>			5 DATE OF BIRTH <b>7/11/10</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>68</b> 2b. HOUR <b>2:20P M</b>				
7a. BIRTHPLACE (State or foreign country) <b>TEXAS</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE COUNTY</b>				
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>VET. ADM. HOSPITAL, FT HOWARD, MD.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>TRUCK</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>QUEEN ANNE</b>			13c. CITY OR TOWN <b>CHESTER</b>			13d. INSIDE CITY - HTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14 FATHER'S NAME First <b>THOMAS</b> Middle <b>QUESENBERRY</b> Last <b>QUESENBERRY</b>			15 MOTHER'S MAIDEN NAME First <b>NANNIE</b> Middle <b>LEWIS</b> Last <b>LEWIS</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes, give year or dates of service) <b>WW II</b>			16b. SOCIAL SECURITY NO <b>212 18 51 48</b>				
17 INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, UNDETERMINED ORGANISM</b> 4-1-77 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>4-1-77</b> (b) <b>PULMONARY EMBOLI</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>??</b> <b>?</b> <b>YEARS</b>			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>LAENNEC'S CIRRHOSIS</b>							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>11/4/68</b> , 19____, to <b>12/5/68</b> , 19____, that <del>(X)</del> (we) last saw the deceased alive on <b>12/5/68</b> , 19____, and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(X)</del> (we) (did) (not) view the body after death.										22b. SIGNATURE <b>Neilson Neilson, M.D.</b>		22c. DATE SIGNED <b>12/6/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>NEILSON NEILSON, M. D.</b>			22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			22f. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>12/9/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK NATIONAL CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>				
24. FUNERAL DIRECTOR <b>Joseph N. Zannino</b>			25a. REC'D BY REG. STRA <b>JOSEPH N. ZANNINO</b>			25b. REG. STRA'S SIGNATURE <b>Charles J. Zannino</b>			25c. DATE <b>DEC 13 1968</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
<div> <div>Items 8, 9, 13 &amp; 14</div> <div>Film 07 12/19/68 kk 171</div> <div>CERTIFICATE OF DEATH</div> <div>17200</div> </div>																	
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D.C.</u>												
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Towson Convalescent Home</u>					d. STREET ADDRESS <u>3409 Bradley Lane</u>												
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Rackstraw</u> Last <u>Rackstraw</u>					4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1968</u>												
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1983</u> <u>Jan. 23, 1880</u>		9. AGE (In years last birthday) <u>88</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian-retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Library of Congress</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>unknown-dec'd Alfred Rackstraw</u>					14. MOTHER'S MAIDEN NAME <u>unknown-dec'd Mary</u>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no none</u>					16. SOCIAL SECURITY NO. <u>Family records</u>												
17. INFORMANT <u>Family records</u>					Address												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c)										INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>March 10, 1968</u> to <u>Dec. 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 11, 1968</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.																	
22a. SIGNATURE <u>Laurence C. Post</u>					22b. DATE SIGNED <u>12/11/68</u>												
22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>					22d. ADDRESS <u>6805 York Rd</u>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12/12/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>											
24. FUNERAL DIRECTOR <u>John Burns Sons 610-12 York Rd. Towson, Md.</u>					25a. REC'D BY REGISTRAR <u>DEC 13 1968</u>												
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>																	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17191

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17201

1. DECEASED NAME (Type or Print) <b>ROBERT KENNETH RAFFERTY</b>			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>12 31 1968</b>			2b. HOUR <b>9:30 PM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>5/2/1937</b>	6 AGE (in years last birthday) <b>31</b> YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>Dec. 31, 1968</b>
7a. BIRTHPLACE (State or foreign) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b>
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Grundy La. In car in front of 5150</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5150 Grundy Lane</b>	
14. FATHER'S NAME First <b>John E.</b> Middle <b>Rafferty</b> Last <b>Rafferty</b>			15. MOTHER'S MAIDEN NAME First <b>Catherine M.</b> Middle <b>Neal</b> Last <b>Neal</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT <b>MARY E. RAFFERTY 5150 GRUNDY LANE BALTIMORE MD. #37</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carbon Monoxide intoxication</b> <b>1520</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1520</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year <b>2 P.M. 12 ? 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Shj. found in auto with vac. cleaner hose running from exhaust into</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Car</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>In front of 5150 Grundy La. Balto. car.</b>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>1/1/69</b>
EXAMINER'S NAME (Type)		ADDRESS		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1/3/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wood Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>McCully 130 E. Fort Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

17192

17202

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8664 Rock Oak Rd</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> d. STREET ADDRESS <b>8664 Rock Oak Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MRS MARY M Reduck</b> 4. DATE OF DEATH <b>DEC 30 1968</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Jan. 29, 1914</b> 9. AGE (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector - Bendix Friez</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John C Young</b> 14. MOTHER'S MAIDEN NAME <b>Lillian Whitlock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>579-09-0429</b> 17. INFORMANT <b>Miss Susan Kline-8664 Rock Oak Rd.</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 41 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arterio Sclerotic and Hypertensive</b> (b) <b>vascular disease</b> 8 yrs DUE TO <b>ATHEROSCLEROSIS</b> (c) <b>16 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4201</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 to <b>Dec 30</b> , 1968, that (I) (we) last saw the deceased alive on <b>9/27</b> 1968, and that death occurred at <b>4:45</b> P.M. from the causes and on the date stated above. 22a. SIGNATURE <b>Wm Conway</b> 22b. DATE SIGNED <b>12/30/68</b> 22c. PHYSICIAN'S NAME (Type) <b>Wm Conway MD</b> 22d. ADDRESS <b>8355 Loch Raven Blvd Towson Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1/2/69</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Baltimore Co., Md.</b>		24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b> 25a. REC'D BY REGISTRAR <b>JAN 2 1969</b> 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOUR				
John Rector									December 5 1968		M				
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (In years lost birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS			
Male		White		August 16, 1880				88 YRS		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md				
Virginia			U.S.A.					Baltimore							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
Catonsville			1700 N. Rolling Road			retired									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER						
Md.			Balto.			Catonsville			1700 N. Rolling Road						
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last			
Albin Rector									Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address						
no			216-09-8982A			Mr. Aikin H. Rector, 1700 N. Rolling Road									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASCENDING CARCINOMA COLON</u>															
DUE TO, OR AS A CONSEQUENCE OF <u>8 ANEMIA</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF <u>ACVD</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cert. examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>56</u> , to <u>1/15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (did not) view the body after death.															
22b SIGNATURE <u>Dr. John Shaw</u>										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>12/5/68</u>			
22d PHYSICIAN'S NAME (Type) <u>Dr. John Shaw</u>										22e ADDRESS <u>5800 Edmondson Ave.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)							
Burial			12/9/68		Western Cemetery			Baltimore, Maryland							
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
Witzke, 4101 Edmondson Ave. 21229						DATE <u>DEC 9 1968</u>		<u>Charles Judge</u>							



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>REESE, MRS. IRENE M.</b>						2a. DATE OF DEATH Month <b>12</b> - Day <b>31</b> - Year <b>68</b>		2b. HOUR <b>1:09</b> M			
3 SEX <b>FEMALE</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>11/22/1885</b>		6. AGE (in years last birthday) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>				Md	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Stella Maris Hospice</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Kirkleigh Villa</b>			
14. FATHER'S NAME First Middle Last <b>William L. Boyd</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Martha J. Lloyd</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>303-07-0442</b>		17. INFORMANT <b>Percy M. Reese III, Address, Gilman School</b> <b>(Hospice records)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>411X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>480X</b> (b) <b>Influenza</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1540 -</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>7/6</b> , 19 <b>68</b> , to <b>12/31</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> , 19 <b>68</b> , and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>Dr. J. David Nagel</b>				22c. DATE SIGNED <b>12/31-68</b>		22d. PHYSICIAN'S NAME (Type) <b>Dr. J. David Nagel</b>		22e. ADDRESS <b>8029 WOODGATE CT.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/3/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>					
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co., 4905 York Rd. Balto. 12, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17205
Item # 8 Film # G408 12/31/68 vmp										CERTIFICATE OF DEATH
1 DECEASED-NAME (Type or print) First Middle Last <b>Charles M. Reinhardt</b>					2a. DATE OF DEATH Month Day Year <b>December 18, 1968</b>			2b. HOUR a. M. <b>4:45</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>May 17, 1897</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>N. Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>railroad</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Me. Pa.</b>		13b. COUNTY <b>1</b>		13c. CITY OR TOWN <b>Balto. Easton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Unknown</b>		
14. FATHER'S NAME First Middle Last <b>4 7</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>7 7</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO <b>716-01-5879</b>			17 INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia.</b> <b>491 X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic bronchitis, senile emphysema.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Arteriosclerosis.</b> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Usualy throat infection.</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (X) (this hospital) attended the deceased from <b>July 10, 1968</b> to <b>Dec. 18, 1968</b> , that (X) (we) last saw the deceased alive on <b>Dec. 18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.										
22b. SIGNATURE <b>Rafael H. Marin</b>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/18/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Rafael H. Marin, M.D.</b>					22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-24-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Towson, Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto., Md. 21202</b>					25a. RECD BY REGISTRAR <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

18-22a Film 408 Maryland State Department of Health Item 10 Film 408 1/9/69 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17198 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17206									
1. DECEASED-NAME (Type or Print)			First Middle Last JEANNE MARY REINHARDT			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR DEATH MATED <input type="checkbox"/> 19		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9-18-1917		6. AGE (in years last birthday) 51 YRS		7c. DATE PRONOUNCED DEAD Month Day Year December 29, 1968	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		2d. HOUR 10:00 P. M.	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 524 Charring Cross Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Frank W. Day, Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Helen Brayden			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. 215-07-5609			17. INFORMANT ADDRESS Phyllis Sheubrook, 6001 Gwynn Oak Ave. 21209						
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Combined effects of barbiturate and ethanol 750.7 DUE TO, OR AS A CONSEQUENCE OF ethanol Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 971.8									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year Hour A.M. P.M. 12-28-68 12-29-68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Took overdose			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State 524 Charring Cross Rd. Baltimore Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Springate, M.D.			22b. DATE SIGNED December 30, 1968						
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-3-1969		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore City Baltimore Md.		
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Avenue 21229					25a. REC'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 105 (4)  
30M REV. 7/68

17197

CERTIFICATE OF DEATH

17207

1 DECEASED-NAME (Type or print) First Middle Last LEAN O Reshl		2a. DATE OF DEATH Month Day Year Dec 5 1968		2b. HOUR 9:10 PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 2/26/98	
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Baltimore		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shangra La Nursing Home		12c. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res-dence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Catonsville	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 411 Oak Court, 21228			
14 FATHER'S NAME First Middle Last John Johnson		15. MOTHER'S MAIDEN NAME First Middle Last Anna			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Mrs. Elizabeth Smith, 411 Oak Court Rd. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro Vasculer Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatoid Arthritis Severe</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>10 years</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>49</u> , to <u>12/5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>My assistant</u>		22b. SIGNATURE <u>Eliot W. Johnson</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED 12/6/68		22d. PHYSICIAN'S NAME (Type) Dr. E. W. Johnson		22e. ADDRESS 3432 Frederick Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/9/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		25a. REC'D BY REGISTRAR DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229					



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First <b>CHARLIE</b>			Middle <b>HAROLD</b>			Last <b>ROBERSON</b>		
2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month		Day		Year		2b. HOUR		M	
		<input type="checkbox"/> 12-15		19		68					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS	
Male		Negro		10-15-46		22 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2c DATE PRONOUNCED DEAD		2d HOUR	
Washington, N.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE		December		4:05	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
(near) Timonium		Harrisburg Expressway		Laborer		Eastern Pro					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		13f	
Md.				Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		HARBAY Street			
14. FATHER'S NAME			First			Middle			Last		
Arthur			Roberson			Lillie			Mae		
15. MOTHER'S MAIDEN NAME			First			Middle			Last		
Worsley											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No.		212-48-6080		Mr. Phillip Worsley		59 S. Morley					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebro-cranial injuries											
812.1 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) storing the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
		3:14 PM 12-15 1968		Occupant in auto-auto collision							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION (Street or R.F.D. No. City or Town County State)							
		Expressway # I-18		Harrisburg Expressway							
				1/4 ml. S. of Padonia Rd. Timonium Balt. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Charles S. Springate, MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
										December 15, 1968	
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		12-19-68		Hodgers Cemetery		Little Washington, N.C.					
24. FUNERAL DIRECTOR				ADDRESS				25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MORTON & DYETT F.H. 1701 Laurens Street				DATE				DEC 17 1968		Charles Judge	



FOR STATE  
HEALTH DEPT.

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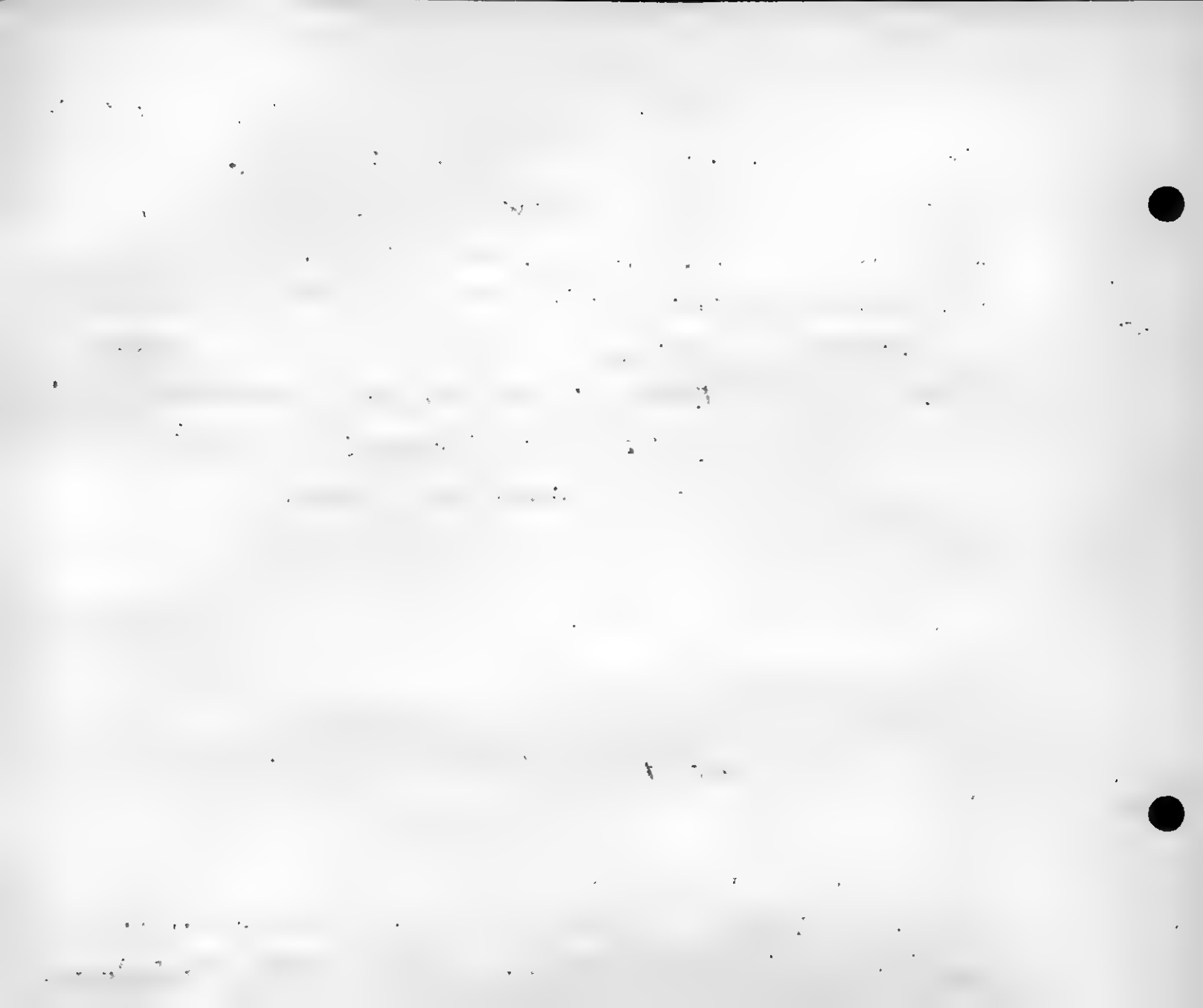
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <b>Phoysius A. ROBL</b>			2a. DATE KNOWN OF EST. DEATH <input checked="" type="checkbox"/> Month <b>12</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>M</b>			
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>6-10-1903</b>	6 AGE (in years last birthday) <b>65</b> YRS	7. UNDER YEAR MONTHS	8. UNDER 24 HRS. DAYS	2c. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>12</b> Year <b>1968</b>		2d. HOUR <b>M</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES OF AMERICA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE ESSEX</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>22 SKIPJACK CT.</b>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>PLUMBER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE ESSEX</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>22 SKIPJACK CT.</b>	
14. FATHER'S NAME First <b>JOSEPH</b> Middle <b>ROBL</b> Last <b>ROBL</b>			15. MOTHER'S MAIDEN NAME First <b>PAULINE</b> Middle <b>SCHRAMER</b> Last <b>SCHRAMER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO <b>215-09-0909</b>			17. INFORMANT ADDRESS <b>ROSE H. ROBL 22 SKIPJACK CT. ESSEX</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>									
DUE TO, OR AS A CONSEQUENCE OF <b>ACHD</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary Occlusion</b>									
19a. DATE OF OPERATION <b>12-14-68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Coronary Occlusion</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>12-14-68</b> HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Coronary Occlusion</b>				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No <b>22 SKIPJACK CT.</b> City or Town <b>ESSEX</b> County <b>BALTIMORE</b> State <b>MARYLAND</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>THEODORE C. PATTERSON</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>12-13-68</b>			
EXAMINER'S NAME (Type) <b>DR. THEODORE C. PATTERSON</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
			ADDRESS (Street, city, town or county) <b>105 MAIN ST. B.O.G.</b>						
23a. BURIAL, CREMATION, REMOVA (Specify) <b>BURIAL</b>		23b. DATE <b>12-14-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM.</b>		23d. LOCATION (City or Town) <b>BALTIMORE</b> (County) <b>MARYLAND</b> (State) <b>MARYLAND</b>			
24. FUNERAL DIRECTOR <b>DIPPEL BROTHERS INC 1800 E. LOMBARD ST. BALTIMORE MARYLAND 21231</b>			25a. REC'D BY REGISTRAR <b>DEC 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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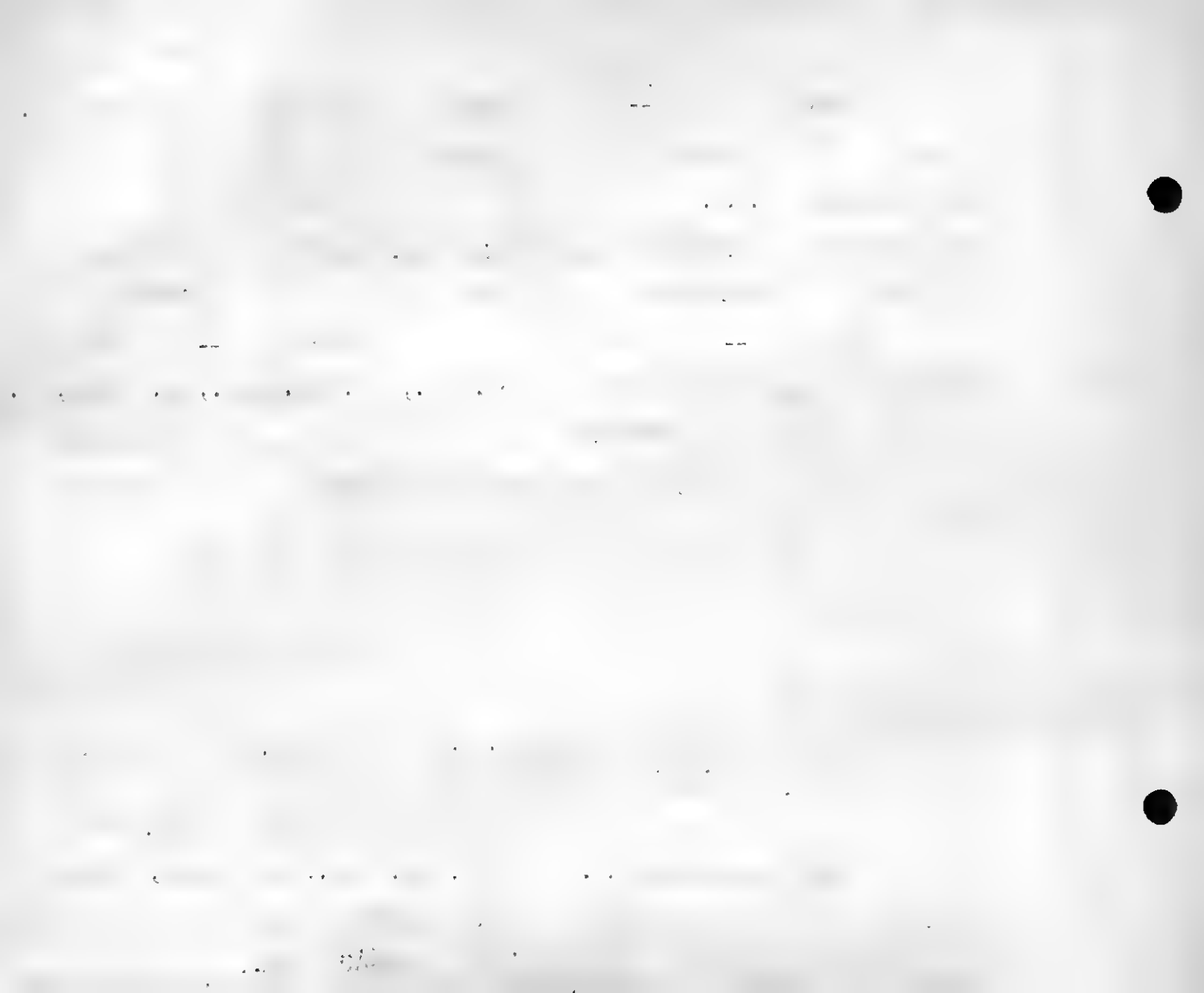
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> <span>17201</span> <span>CERTIFICATE OF DEATH</span> <span>17211</span> </div>										
1 DECEASED NAME (Type or print) <b>LEON CLARENCE ROHRER</b>					2a. DATE OF DEATH Month <b>DECEMBER</b> Day <b>15</b> Year <b>1968</b>			2b. HOUR <b>9:50 A.M.</b>		
3 SEX <b>M</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>5/4/02</b>		6 AGE (in years last birthday) <b>66</b> YRS.		7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County, Md.</b>				
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>MAINTENANCE SUPERVISOR COAL MINE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>Middle River</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>37 HONEYCOMB Rd</b>	
14. FATHER'S NAME First <b>SOLOMON</b> Middle <b>HUMMEL</b> Last <b>KATE</b>			15. MOTHER'S MAIDEN NAME First <b>ROHRER</b> Middle <b>ROHRER</b> Last <b>ROHRER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>178056519</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>INTERSTITIAL PULMONARY FIBROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5101</b> (b) <b>PROBABLE ANTHRACO-SILICOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 25, 1968</b> , to <b>Dec. 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>William Newcomer</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Dec. 15, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>					22e. ADDRESS <b>Mount Wilson, Maryland</b>					
23a. BURIAL, CREMATION, or other disposition (Type) <b>BURIAL</b>		23b. DATE <b>12/18/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		23d. LOCATION (City or Town) <b>Baltimore Co., Md.</b> (County) (State)				
24. FUNERAL DIRECTOR <b>Brazdzinski Funeral Home</b> ADDRESS <b>1407 Eastern Ave.</b>					25a. REC'D BY REGISTRAR <b>DEC 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
EARL			--			ROWLETT			DECEMBER 28, 1968 12:22 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
MALE		NEGRO		OCTOBER 26, 1911			57 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
PENNSYLVANIA			U.S.A.						BALTIMORE Md		
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD				VETERANS ADMINISTRATION HOSP.				LABORER		STEEL	
13a USUAL RESIDENCE (Where deceased lived, if institution, give street address)				13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER			
MARYLAND				ANNE ARUNDEL		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6564 HALL AVENUE			
14 FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last		
EDDIE			-- ROWLETT			GERTRUDE			-- HUDSON		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT Address					
YES				WWII		213 07 6429		CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										TERMINAL	
IMMEDIATE CAUSE (a) PNEUMONIA											
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LARYNX WITH METASTASIS										YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
161X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
22a. I certify that (u) (this hospital) attended the deceased from Sept. 5, 1968, to Dec. 28, 1968, that (u) (we) last saw the deceased alive on Dec. 28, 1968 and that in (u) (our) opinion death occurred on the date and hour and from the causes stated above, (u) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Pushpendra Senan						12 29 68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
PUSHPENDRA SENAN, M.D.						VET. ADM. HOSP., FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			1/2/69			BALTIMORE NATIONAL CEMETERY			BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Charles R. Law						802 Madison Ave			JAN 6 1969		





**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 11/72

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17203											
17213											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <b>Melvin</b>		Middle <b>nmn</b>		Last <b>Rubin</b>		2a. DATE OF DEATH <b>12 Month 17 Day 68</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12-24-02</b>			6. AGE (In years last birthday) <b>65 YRS.</b>		2b. HOUR <b>7:40 P M</b>		
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. County Gen. Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETAIL</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>SALES</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>5420 Jenquil Ave.</b>		
14. FATHER'S NAME First <b>Isreal</b>			Middle <b>Rubin</b>		15. MOTHER'S MAIDEN NAME First <b>Estelle</b>			Middle <b>not known</b>		Last <b>not known</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address <b>MRS. ESTELLE I. ROLL, 3413 MARYVALE ROAD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4109</b> <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerosis</b> most <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4211</b>											
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-17</b> , 19 <b>68</b> , to <b>12-17</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-17-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Angela</i>		22c. DATE SIGNED <b>12-17-68</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (Type) <b>ANGELA</b>		22e. ADDRESS <b>TOPACIO</b>		22f. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-19-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HAR ZION TIFERETH ISRAEL</b>		23d. LOCATION (City or town) <b>ROSEDALE, MARYLAND</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1968</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
30M REV. 6-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Blanche</b>			First <b>M.</b> Middle <b>Russell</b> Last			2a. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1968</b>		2b. HOUR <b>4:45</b> PM	
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 22, 1890</b>		6 AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>824 Wise Ave.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3417 Elliott St.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>Lewis</b> Last			15. MOTHER'S MAIDEN NAME First <b>Eugena</b> Middle <b>Moon</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>220-46-7661</b>		17. INFORMANT (Daughter) <b>Mrs. Audrey M. Szeliga, 1517 Wilson Pt. Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF COLON</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>1958</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HYPERTENSIVE C.V. DISEASE</b>									
19a. DATE OF OPERAT ON <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NONE</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <b>NONE</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>NONE</b>					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>NONE</b>		21f. LOCATION Street or R.F.D. No <b>NONE</b>		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-4-64</b> , 19 <b>68</b> , to <b>12-1-</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>DEC 1</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. G. Schimunek M.D.</b>				DEGREE <b>M. D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>12/3/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Emmanuel A. Schimunek</b>				22e. ADDRESS <b>842 S. East Ave. Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		23b. DATE <b>12/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>			
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

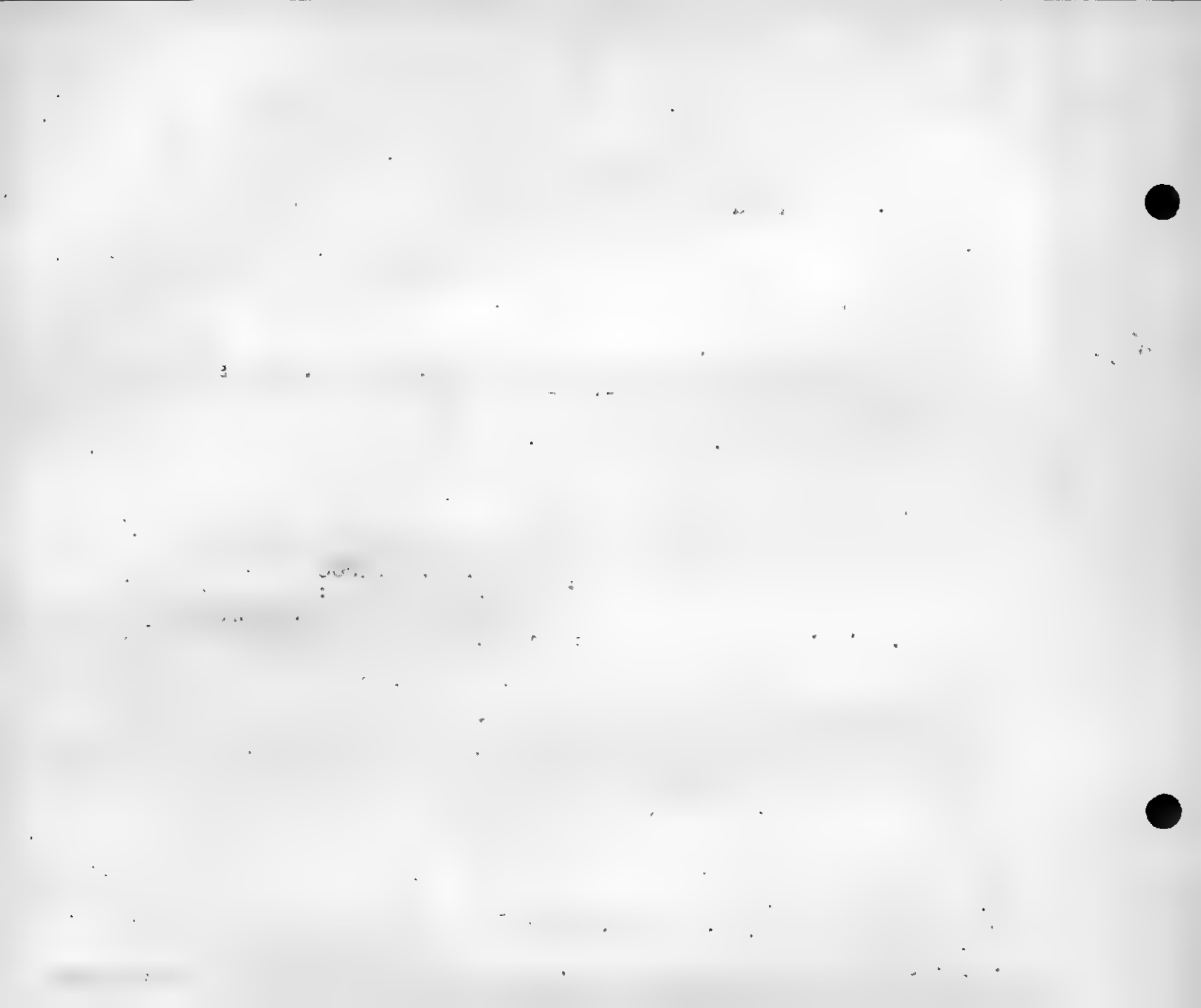
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17205 CERTIFICATE OF DEATH 17216									
1. DECEASED-NAME (Type or print) First Middle Last EDWARD RUSZKIEWICZ			2a. DATE OF DEATH Month Day Year December 12, 1968			2b. HOUR 9:15 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 18, 1891.		6. AGE (In years last birthday) 77 YRS.		F UNDER 1 YEAR MONTHS DAYS H UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Lodz, Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Eastpoint		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 415 Soarsdale Rd. #24.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Eastpoint		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 415 Soarsdale Rd. #24	
14. FATHER'S NAME First Middle Last Stephen Ruszkiewicz			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Sarafin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 169-03-1040		17. INFORMANT Anna Ruszkiewicz		Address Same.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Debility</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebro-Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardio-Vascular Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>443X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , to <u>Dec. 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 8, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Manuel P. DeLeon</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/13/68</u>		
22d. PHYSICIAN'S NAME (Type) Manuel P. DeLeon					22e. ADDRESS <u>7840 Eastern Ave. Balt. Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-14-68.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		23d. LOCATION (City or Town) (County) (State) <u>Kenwood Av. &amp; Trumps Mill Rd., Md.</u>			
24. FUNERAL DIRECTOR <u>Charles S. Geiler</u>					ADDRESS <u>6224 Eastern Ave. Balto., 21224, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
17296		CERTIFICATE OF DEATH						17217					
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR p. m.		
Addie			VIRGINIA		Ryer				Wed. December 11, 1968		5:30 p.		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
female		white		Jan. 8, 1883				85 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		9. COUNTY OF DEATH					
Md., Crisfield, Somerset			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		Baltimore					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Catonsville			SPRING GROVE STATE HOSP.				housewife		AT Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Md.					Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19 East Fort Avenue				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME				
George Washington Wyatt									Melissa Walker 1417 Hanover St				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))						
			215-09-4882-B		Mrs. Ethel P. Williams		PART I. DEATH WAS CAUSED BY:						
					Records: SPRING GROVE STATE HOSP. ITAL		IMMEDIATE CAUSE (a) ASHD with heart failure						
							DUE TO, OR AS A CONSEQUENCE OF						
							(b) generalized arteriosclerosis						
							DUE TO, OR AS A CONSEQUENCE OF						
							(c)						
							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.						
							Dec. 16, 1968						
							Right hip fracture						
							Approved By: [Signature]						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. (If yes, were findings considered in certifying cause of death?)				
Dec. 16, 1968			Balto				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6014 Edmondson Ave 21228				
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
<input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			8 P.M. 8 Month Day Year 1968		Patient, turned, slipped & fell								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work			Home		19E Fort Ave Balto Md 21230 (Home)								
22a. I certify that (this hospital) attended the deceased from Oct. 25, 1968, to Dec. 11, 1968, that (we) last saw the deceased alive on Dec. 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								22c. DATE SIGNED					
[Signature]								12-11-68					
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
ROBERTO M. GUTIERREZ								SPRING GROVE HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City or Town) (County) (State)						
Burial			Dec. 16, 1968		[Signature]		Brooklyn, Md						
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
[Signature]			DEC 18 1968		[Signature]								





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
17207					17218								
Item 5 Film 07 12/23/68 kk					CERTIFICATE OF DEATH								
1 DECEASED-NAME (Type or print) <i>Anna</i>			First		Middle <i>B.</i>		Last <i>SABALAUSKAS</i>		2a. DATE OF DEATH <i>Dec</i> Month <i>13</i> Day <i>68</i> Year		2b. HOUR <i>2:48</i> M		
3 SEX <i>Female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>July 26, 1891</i>		6. AGE (In years - last birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md							
10. CITY OR TOWN OF DEATH <i>Catonsville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1335 Herkimer St.</i>		21223		
14 FATHER'S NAME <i>Unknown</i>			First		Middle		Last		15. MOTHER'S MAIDEN NAME <i>Unknown</i>			First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO <i>212-07-2368</i>		17 INFORMANT <i>Mr. John Sabalauskas, 128 Westowne Place</i>			Address <i>21229</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i> <i>1519</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1519</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (the hospital) attended the deceased from <i>8-15-68</i> to <i>12-13-68</i> , that (I) (we) lost saw the deceased alive on <i>12-9-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (deceased) view the body after death													
22b. SIGNATURE <i>John A. Nesbitt Jr</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>12-13-68</i>							
22d. PHYSICIAN'S NAME (Type) <i>JOHN A. NESBITT JR</i>		22e. ADDRESS <i>1009 Frederick St Baltimore Md 21225</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>12-16-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>							
24. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>DEC 17 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>							



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
2  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR				
HELEN			BARBARA			SADOWSKI			Month Day Year 12 27 68 5:15 PM				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.		
Female		White		7-20-1900			68 YRS						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Maryland			U.S.A.						BALTIMORE			Md.	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
TOWSON			St. Joseph's			Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			748 S. Decker Ave, 21224	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME										
John			Kwiatkowski			Antoinette Napierawa							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 220-07-0957A			17. INFORMANT			Address				
						Mr. Leo Sadowski, 748 S. Decker Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diffuse Interstitial Pneumonia, bilateral													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
last													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from 12-21, 19 68, to 12-27, 19 68, that (X) (we) last saw the deceased alive on 12-27, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
Samuel C. H. Lee, M.D.			7620 York Rd., Towson, Maryland 21204										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			12/31/68			St. Stanislaus			Baltimore, Maryland				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
M.F.SADOWSKI & SONS, 1808 EASTERN AVENUE						DATE DEC 30 1968			J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

17220

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17220

1 DECEASED NAME (Type or print) <b>EDWARD FRED SAEHLER</b>			2a DATE OF DEATH Month <b>DECEMBER</b> Day <b>22</b> Year <b>1968</b>			2b HOUR <b>6:00A</b>					
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>APRIL 23, 1890</b>		6 AGE (In years last birthday) <b>78</b> YRS.		7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7 UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a BIRTHPLACE (State or foreign country) <b>MINNESOTA</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>BALTIMORE,</b> Md					
10 CITY OR TOWN OF DEATH <b>TOWSON</b>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>BARBER</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>			13b COUNTY <b>BALTIMORE</b>			13c CITY OR TOWN <b>ESSEX</b>		13d INS DE CITY (M/T)? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>26 EVERLASTING ST. #21220</b>	
14 FATHER'S NAME First <b>FRANK</b> Middle <b>SAEHLER</b> Last <b>SAEHLER</b>			15 MOTHER'S M A DEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>UNK</b> (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT <b>MAE SAEHLER</b>			Address <b>ABOVE</b>		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>450X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>450X</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <b>December 18, 1968</b> , to <b>December 22, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 22, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Samuel C. Lee, M.D.</b>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED <b>December 22, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Samuel C. Lee, M.D.</b>						22e ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>			23b DATE <b>12/24/68</b>			23c NAME OF CEMETERY OR CREMATORY <b>LONDON PARK</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD</b>		
24 FUNERAL DIRECTOR <b>J.E. CONNELLY SONS</b>						ADDRESS <b>300 MACE</b>			25a REC'D BY REGISTRAR <b>DEC 24 1968</b>		
									25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



FOR STATE  
HEALTH DEPT.

17210

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17221

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF EST DEATH MATED <input checked="" type="checkbox"/> Dec. 14, 68		2b HOUR 5:30 AM	
Concetta Catherine Sappington											
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
F M	White	July 8, 1924	44 YRS					Dec 14 1968		M	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Frederick		U.S.A.				Baltimore County					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Randallstown		Balto. Co. Gen. Hospt.		House Wife							
13a USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Balto.		Balto. #7				8052 Milton Ave.		21207	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Charles Marino								Catherine Marino (nee Marino.)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
NO		216/20/5813		James L. Sappington		8052 Milton Ave.		21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral aneurysm - left</u>										3 hrs	
4369 DUE TO, OR AS A CONSEQUENCE OF											
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
331X Diabetes Mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>J. Nelson McKay</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED 12/14/68			
EXAMINER'S NAME (Type) J. Nelson McKay											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Dec. 16, 68		Lake View Memorial Park		Liberty Rd. Balto. Co. Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Loring Byers 8728 Liberty Rd. Randallstown				21133				DATE DEC 17 1968		Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17222

1 DECEASED-NAME (Type or print) <b>LAWRENCE</b>			First Middle Last <b>G. SCARBOROUGH</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>8</b> Year <b>1968</b>			2b HOUR <b>3:25</b> <sup>a</sup> <sub>M</sub>		
3 SEX <b>Male</b>		4. RACE <b>White</b>		5 DATE OF BIRTH <b>November 18, 1904</b>		6 AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			Md		
10 CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Disabled Inspector</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Die craft</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INS DE CITY, MD, IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>527 St. Francis Road #21204</b>			
14. FATHER'S NAME First Middle Last <b>Lawrence C. Scarborough</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Lucy Chamberlain</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16b SOCIAL SECURITY NO <b>215-10-6580</b>		17 INFORMANT Address <b>Hosp. Records</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> <b>4389</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Malacia</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Bilateral Bronchopneumonia</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (A) (this hospital) attended the deceased from <b>12-1-</b> , 19 <b>68</b> , to <b>12-8-</b> , 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>12-8-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>I Cilliani</b>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-8-68</b>							
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>		22e. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR ADDRESS <b>C.F. EVANS &amp; SON 8802 Harford road</b>		25a. REC'D BY REG STRAR <b>DEC 10 1968</b>		25b. REG STRAR'S SIGNATURE <b>J. Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the other pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

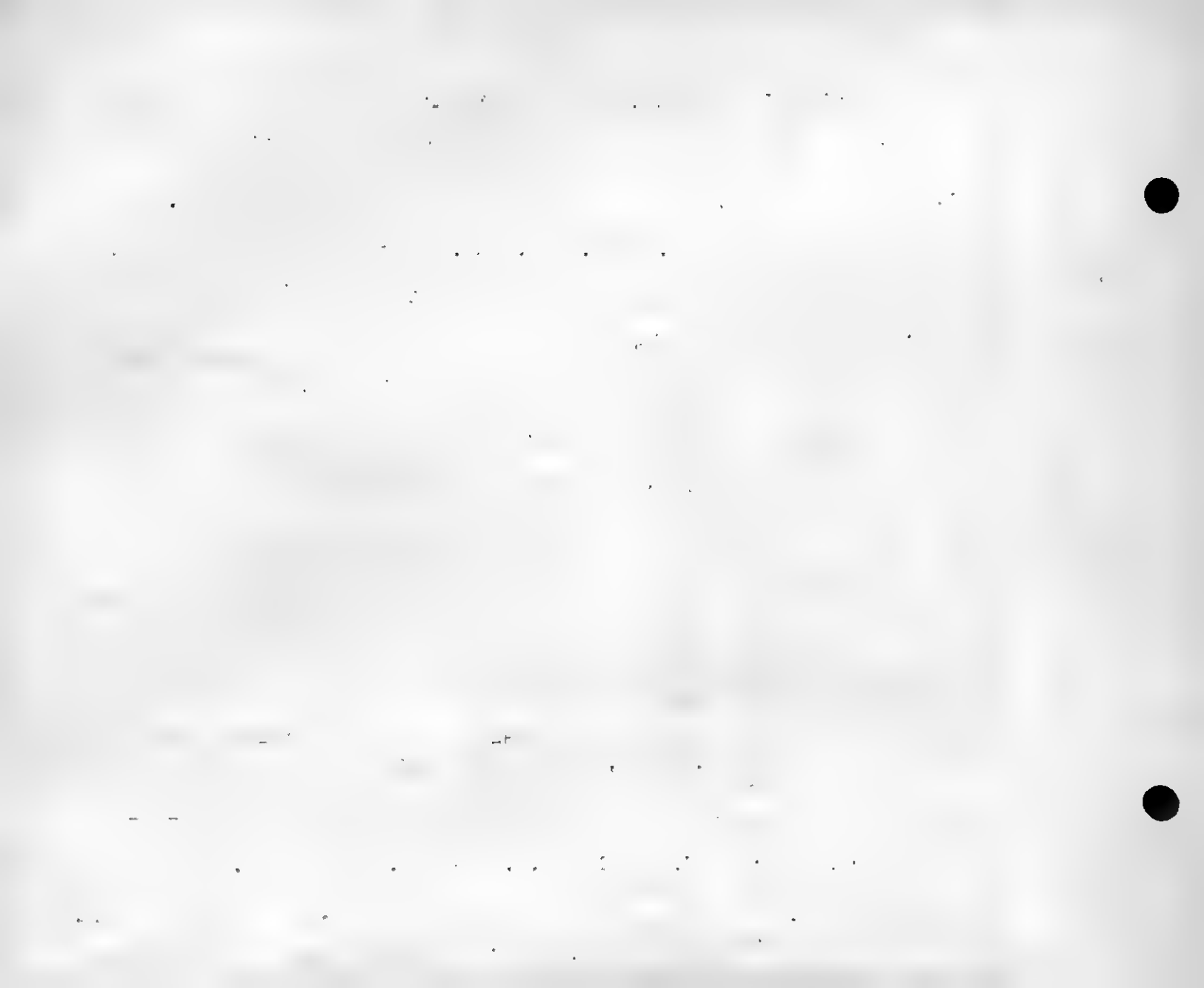
17212

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17223

1. DECEASED NAME (Type or print) <b>CATHERINE ADALENE SCHAEFFER</b>			2a. DATE OF DEATH 12 Month 29 Day 68 Year			2b. HOUR 1:36 a.m.	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH 9-13-1913		6. AGE (in years last birthday) 55 YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE Co.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. CEN.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>FACTORY WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHOE CO.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>TANEYTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>STUMPTOWN ROAD</b>		14. FATHER'S NAME First Middle Last <b>RAYMOND JENKINS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>LELI FRANKLIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220 26 0290</b>		17. INFORMANT <b>MRS JOHN FOGLE REISTERSTOWN, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> <b>107</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA of GENITALIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>1167 MALNUTRITION</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <b>10-11</b> , 1968, to <b>12-29</b> , 1968, that (I) (we) saw the deceased alive on <b>December 29</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Josefina C. Aguilar</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-29-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. JOSEFINO C. AGUILAR M.D.</b>				22e. ADDRESS <b>6701 N. CHARLES ST. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Dec. 31 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Winfield Carroll Md.</b>	
24. FUNERAL DIRECTOR <b>Thomas D. Fletcher</b>				25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
45M - 1-68

17213										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17224									
1 DECEASED NAME										2a. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										Hour Min									
1 DECEASED NAME Mary - SCHELLENSCHLAGER										2a. DATE OF DEATH 12 20 68										2b. HOUR 5:45 AM									
3 SEX Female										4. RACE White										5 DATE OF BIRTH 6/30/20									
7a BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
7a BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										9. COUNTY OF DEATH Baltimore									
10. CITY OR TOWN OF DEATH Owings Mills										11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Rosewood State Hospital										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dependent									
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland										13b COUNTY Baltimore										13c CITY OR TOWN Baltimore									
14. FATHER'S NAME Mathias Schellenschlager										15. MOTHER'S MAIDEN NAME Eva Constance Schellenschlager										16a WAS DECEASED EVER IN U.S. ARMED FORCES? no									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? no										16b. SOCIAL SECURITY NO none										17 INFORMANT Rosewood Records, Owings Mills, Maryland									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> 313X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>3255</u> (b) <u>Aspiration of Gastric Contents Terminal</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Terminal</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>39 yrs</u>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe mental retardation, 18.5% intellectual, 20% low</u>										19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes																			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)									
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f LOCATION Street or RFD No City or Town County State									
22a I certify that (a) (this hospital) attended the deceased from <u>6/29</u> , 19 <u>68</u> , to <u>12/20</u> , 19 <u>68</u> , that (b) (we) last saw the deceased alive on <u>12/20</u> , 19 <u>68</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.										22b SIGNATURE <u>Richard A. Jones</u>										22c DATE SIGNED 12/20/68									
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.										22e ADDRESS Rosewood State Hospital, Owings Mill, Md.																			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial										23b DATE DEC 23 1968										23c NAME OF CEMETERY OR CREMATORY Meadow Ridge Howard Co									
24. FUNERAL DIRECTOR <u>William L. Jones</u>										25. REC'D BY REGISTRAR DEC 26 1968										25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
Items 5&6 Film 408 1/23/69 kk													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR	
Henry				A. Schmidl				Month 12 Day 26 Year 1968				655 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Oct. 14, 1897 July 14, 1894				71 7/4 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				Md	
Maryland		U.S.A.						Baltimore,					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Towson				St. Joseph Hospital				Retired-Machinist				Trimble & Fink Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland				Balto.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2211 Taylor Ave.			
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
Schmidl				Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17 INFORMANT Address							
No						James Godzik, 60 Acorn Circle							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cerebral hemorrhage</u>													
4319 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from 12/25/1968, to 12/26/1968, that (A) (we) last saw the deceased alive on 12/26/1968, and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/26/68					
22d. PHYSICIAN'S NAME (Type) L. CILLIANI, M.D.				22e. ADDRESS 7620 York Rd., Towson, Md. 21204									
23a. B. RIAL CREMATION REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				12/30/68		Glen Haven				Glen Burnie, AACo., Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H.W. Jenkins & Sons Co.				4905 York Road Balto. 12, Md.				JAN 2 1969		Charles Judge			









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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First Middle Last		SCHOPPERT		2a. DATE OF DEATH		2b. HOUR	
Sadie		M		SCHOPPERT		Month Day Year 12 14 68		7:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		11-12-80		88 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Balto			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		8110 Oakleigh Road		Housewife		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md		Balto				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8110 Oakleigh Rd. 21204	
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
Dennis Splaine				Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		215 05 1495		Harry E. Shoppert		21204 8110 Oakleigh Rd.			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiomyopathy</u>								14	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u>								20 years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Dr. Samuel I. O'Mansky								12-16-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Dr. Samuel I. O'Mansky				8523 Loch Raven Blvd. 21204					
23a. BURIAL, CREMATION, REMOVAL, ETC.		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-17-68		New Cathedral Cemetery		Balto. Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Johnson Funeral Home		21204		DEC 19 1968		Charles Judge			



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Item 14 Film 0407 12/16/68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 <b>17217</b> <b>CERTIFICATE OF DEATH</b> <b>17228</b>													
1 DECEASED NAME (Type or print) First Middle Last <b>M. Anna Schramm</b>						2a. DATE OF DEATH Month Day Year <b>December 5 1968</b>				2b. HOUR <b>M</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>March 13, 1880</b>			6 AGE (n years last birthday) <b>88</b> YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.							
10 CITY OR TOWN OF DEATH <b>Baltimore</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Armecost Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>none</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto</b>		13d. HSIDE CITY LINK TSP <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>4637 Manordene Rd., 21229</b>				
14 FATHER'S NAME First Middle Last <b>John E. Schramm Kling</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Caroline Brack</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO <b>212-16-8199D</b>		17 INFORMANT Address <b>Mrs. Carolyn Preston, 6123 Falls Road,</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> 5 Day <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebrovascular</b> 10 yr DUE TO, OR AS A CONSEQUENCE OF (c) <b>Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4701X</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 10, 1968</b> to <b>December 5, 1968</b> , that (I) (we) last saw the deceased alive on <b>5 December 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Charles F. O'Donnell</b>				ATTENDING PHYSICIAN MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/6/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>				22e. ADDRESS <b>7501 York Road, 21204</b>									
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>						
24. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave. 21229</b>				25a. REC'D BY REGISTRAR <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

4.3

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

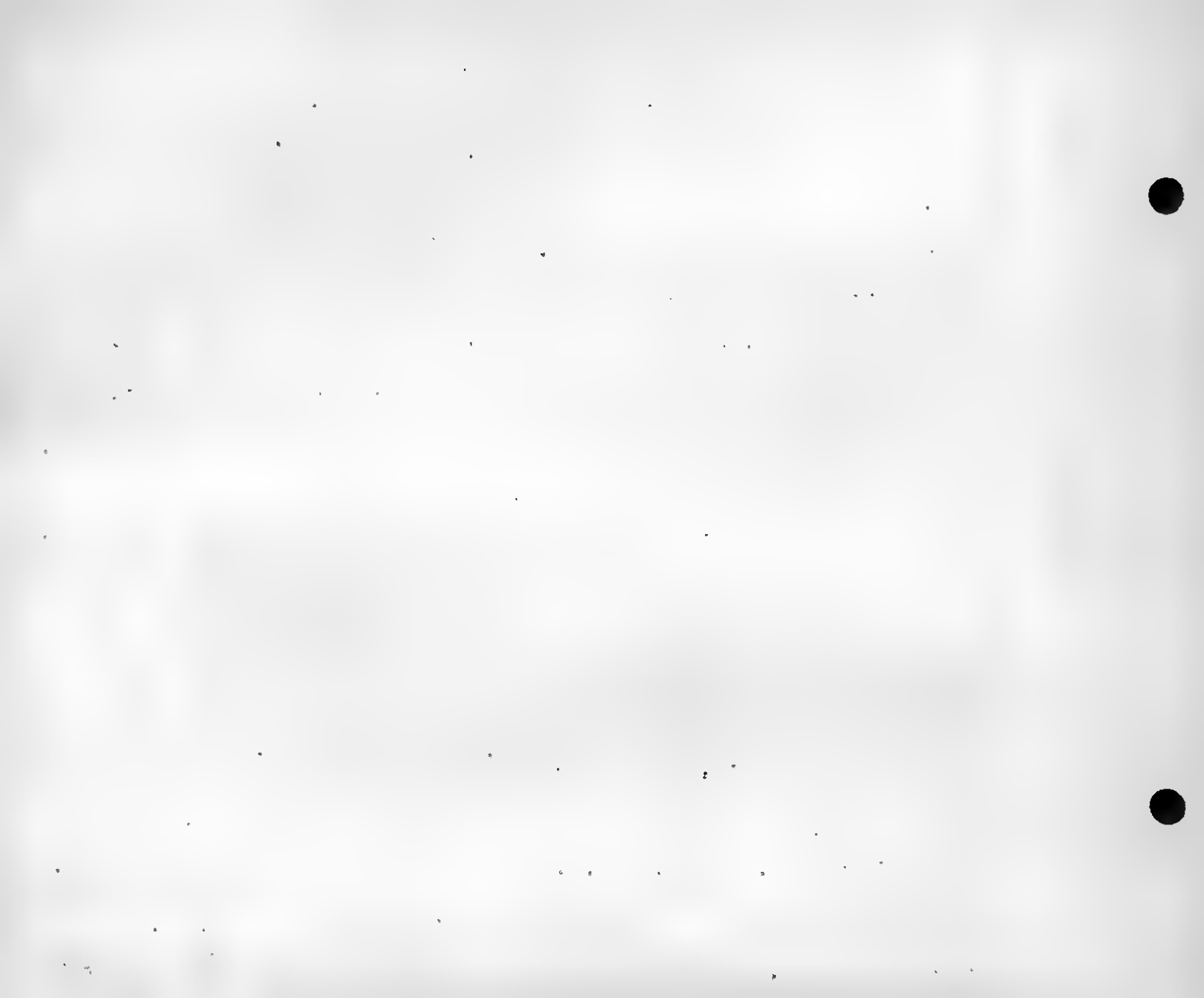
17218

CERTIFICATE OF DEATH

17229

1. DECEASED-NAME (Type or print) <i>Virginia</i>			First Middle Last <i>v. Schutz</i>			2a. DATE OF DEATH Dec. Month <i>30</i> , Day <i>68</i> Year			2b. HOUR M		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>Sept. 7, 1922</i>			6. AGE (In years last birthday) <i>46</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Balto. City</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i> Md.		
10. CITY OR TOWN OF DEATH <i>Reisterstown</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>209 Glyndon Drive</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>			13c. CITY OR TOWN <i>Reisterstown</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <i>Charles v. Whorton</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Ethel Pense</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>212-20-6632</i>			17. INFORMANT Address <i>Mr. William R. Schutz Reisterstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Uremia</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Multiple Metastases from</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma breast</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>  <i>3 yrs.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 26</i> , 19 <i>68</i> , to <i>Dec. 30</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Dec. 29</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Martin E. Strobel</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>12-31-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Martin E. Strobel, M.D.</i>			22e. ADDRESS <i>59 Hanover Rd. Reisterstown, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>Jan. 2, 68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley Gardens</i>			23d. LOCATION (City or Town) (County) (State) <i>Cockeysville, Md.</i>		
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>			ADDRESS <i>Reisterstown, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>JAN 3 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

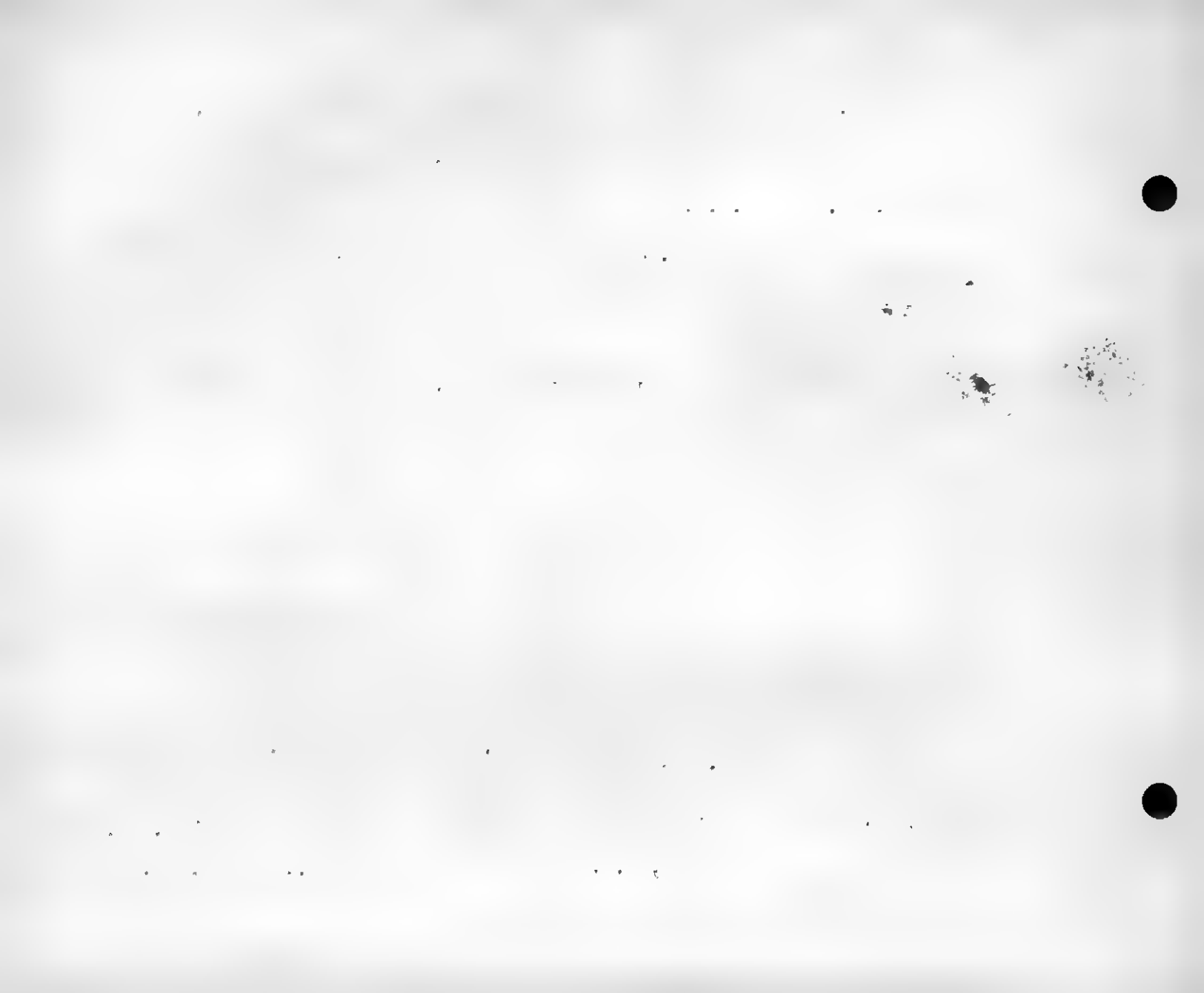
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17219

17230

1 DECEASED NAME (Type or print) <b>E. MARIE SCHWEIGER</b>			2a DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>1968</b>			2b HOUR <b>8:40</b> M			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>June 9, 1994</b>		6 AGE (In years last birthday) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b> Md			
10 CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>At Home</b>		12b KIND OF BUSINESS OR INDUSTRY <b>*****</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution) STATE <b>Md.</b>		13b CITY OR TOWN <b>Balto</b>		13c CITY OR TOWN <b>Parkville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>8811 Baker ave</b>	
14 FATHER'S NAME <b>John E. Whittington</b>			15 MOTHER'S MAIDEN NAME <b>Rachel E. Ward</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b SOCIAL SECURITY NO <b>*****</b>		17 INFORMANT <b>Family records</b>		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR HEMORRHAGE</b> <b>4219</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331X</b>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 5, 1968</b> , to <b>Dec. 10, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 10, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Regalado T. Dizon</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Dec. 10, 1968</b>	
22d PHYSICIAN'S NAME (Type) <b>Regalado T. Dizon, M.D.</b>				22e ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>12/13/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24 FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford rd.</b>				ADDRESS		25a REC'D BY REGISTRAR <b>DEC 16 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17220										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17231									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
CLARENCE EDWARD SCOTT										Month 12 Day 18 Year 88										4:35 AM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (in years last birthday)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS														
MALE			Negroid			1/27/94			74 YRS.			MONTHS			DAYS			HOURS											
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										Md										
VIRGINIA			U.S.A.						BALTIMORE COUNTY,																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY																				
FORT HOWARD			VET. ADM. HOSPITAL			LONGSHOREMAN			SHIPPING																				
13a. USUAL RESIDENCE (Where deceased admsion) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER																				
MARYLAND			BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3309 Paton Ave.																				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
JUNIOR SCOTT			ELEANORA UNKNOWN																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war and dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address																				
YES			705 10 33 49			CLIN. RECORDS, VA HOSP. FT HOWARD, MD.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1 DEATH WAS CAUSED BY.										6 DAYS																			
IMMEDIATE CAUSE (a) 4339 ACUTE HEART FAILURE																													
DUE TO, OR AS A CONSEQUENCE OF																													
GASTROINTESTINAL BLEEDING										4 DAYS																			
DUE TO, OR AS A CONSEQUENCE OF																													
RIGHT SIDE HEMIPLEGIA DUE TO MIDDLE CEREBRAL ARTERY																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										THROMBOSIS																			
332X																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			NO AUTOPSY																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)																							
			HOUR A.M. Month Day Year																										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc)			21f. LOCATION			Street or R.F.D. No			City or Town			County														
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																													
22a. I certify that (this hospital) attended the deceased from 12/12/68, 19, to 12/18/68, 19, that (I) (we) last saw the deceased alive on 12/18/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			22c. DATE SIGNED																										
George C. McElpatrick, M.D.			12/18/68																										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																										
GEORGE C. MC ELPATRICK, M. D.			VAH FORT HOWARD, MARYLAND																										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)			(State)														
BURIAL			12/23/68			BALTO NATIONAL			BALTIMORE, MARYLAND																				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																							
V. R. Bailey			KELSON FUNERAL HOME			DEC 23 1968			Charles Judge																				
			1348 N. Calhoun St. Balto. Md.																										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
RUTH			ADAMS			SCOTT			12 Month 24 Day 6 Year 11 40 AM					
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS		7. UNDER 24 HRS HOURS MIN			
FEMALE		CAUCASIAN		5-1-1875			93 YRS.							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
NEW JERSEY			USA						BALTIMORE			Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON			BETH EL EMBROIDERY			HOMEMAKE								
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
FLORIDA						MIAMI		YES <input type="checkbox"/> NO <input type="checkbox"/>		590 MELALEUCA LANE				
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last											
R. V. - JOHN F. ADAMS			UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address					
NO			216-46-8600			MERCANTILE - SAFE DEPOSIT + TRUST			13 SOUTH ST.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure														
794X DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Age related illness														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
794X														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 4/1/62, 1962, to 12/24, 1968, that (I) (we) saw the deceased alive on 12/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
CREMATION			12/27/68			GREEN MOUNT			BALTIMORE, MD					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
MITCHELL - WIEDEFELD HOME, INC.			DATE DEC 27 1968			Charles Judge								
6500 YORK RD. 21212														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115  
45M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Joseph James Scully						Month	Day	Year	255 P M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS	
Male		White		November 27, 1892		76 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore, Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Towson			St. Joseph Hospital Retired Blacksmith						B & O R.R.
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. ASIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
Maryland						Baltimore			7207 Lanark Rd.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Thomas P. Scully						Mary Bergen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			705 03 9411			Agnes H. Scully			7207 Lanark Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Fibrosis, and Pulmonary Edema and									
DUE TO, OR AS A CONSEQUENCE OF Bronchopneumonia									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from 12/23/ 19 68, to 12/29/ 19 68, that (A) (we) last saw the deceased alive on 12/29/ 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Christine Feliciano, M.D.					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/29/68		
22d. PHYSICIAN'S NAME (Type) Christine Feliciano M.D.					22e. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/2/1969		Holy Cross		Richie Hgw. A.A.Co. Md.			
24. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.					25a. REC'D BY REGISTRAR ADDRESS		25b. REGISTRAR'S SIGNATURE		
					JAN 6 1969		Charles Judge		

MEDICAL CERTIFICATION





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form B-15. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit (File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17223

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17234

1 DECEASED NAME (Type or Print) <i>Paul M. Sebesta Jr.</i>		First <i>M.</i> Middle <i>Sebesta</i> Last <i>Jr.</i>		2a. DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> <i>Dec. 21, 1968</i>		2b. HOUR <i>5p.m.</i>	
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>9-15-52</i>	6 AGE (In years last birthday) <i>16</i> YRS	7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	8 UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>Dec.</i> Day <i>21</i> Year <i>1968</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Rosedale</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>821 Rosedale Ave.</i>		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <i>None</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Rosedale</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <i>Paul M. Sebesta Sr.</i>		First <i>M.</i> Middle <i>Sebesta</i> Last <i>Sr.</i>		15. MOTHER'S MAIDEN NAME <i>Mary C. Myers</i>		13e. STREET AND NUMBER <i>821 Rosedale Avenue</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>none</i>		17. INFORMANT <i>Paul M. Sebesta Sr.</i> ADDRESS <i>821 Rosedale Avenue</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Palsy</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>334.1</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Thos C. Patterson</i>		EXAMINER'S NAME (Type) <i>Thos C. Patterson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>12/23/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-24-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR <i>Thos C. Patterson</i>		ADDRESS <i>1211 Chesaco Avenue</i>		25a. REC'D BY REGISTRAR <i>DEC 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH	
WILMER							SEITZ		Month 12 Day 23 Year 68 3:55 P.M.	
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR	
MALE		WHITE		9-16-07			61 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
MARYLAND		U.S.A.					BALTIMORE		Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
TOWSON			St. Joseph's Hospital			LABOR			BALTO CITY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY L.H. 75? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Baltimore		Parkville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8854 Belair Road	
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME	
ALBERT			SEITZ				FANNY		HORNUNG	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
YES			WORLD WAR II 212-10-7758		Admission sheet/wife					
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute recurrent myocardial infarction										
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from 12-8-68, 1968, to 12-23-1968, that (we) last saw the deceased alive on 12-23-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE		22c. DATE SIGNED								
		12-23-68								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
Dr. Reynaldo Orjuela-Gomez		7620 York Rd., Towson, Maryland 21204								
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		DEC 26 1968		MORELAND MEMORIAL PARK		TAYLOR AVE BALTO MD				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
THE DIPPEL BROS INC		7710 BELAIR RD		DEC 27 1968		Charles Judge				



17235

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17236

## CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) <b>Jeannette C. Seward</b>		2. DATE AND HOUR OF DEATH <b>12/20/1968</b> <b>9:40 P.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BALTIMORE COUNTY</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>8 E. Overlea Ave</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>8 E. Overlea Ave</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 2, 1879</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>89</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ferfinand Goodhues</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Douglas</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216 46 7920</b>	
17. INFORMANT <b>George S. Goodhues</b>		ADDRESS <b>106 Homeland Ave</b>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>4129 Influenza</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Congestive heart failure</b> <b>due to arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b> <b>2 wks.</b>	
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 16</b> 19 <b>68</b> to <b>Dec 20</b> 19 <b>68</b> that (I) (we) last saw the deceased alive on <b>Dec 20</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Charles M. Kerr</b> DEGREE		23B. DATE SIGNED <b>Dec 21, 68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Charles M. Kerr</b> DEGREE		23D. ADDRESS <b>6801 Belair Rd.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/23/1968</b>	24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1968</b>		25B. NAME OF REGISTRAR <b>Charles Judge</b>	
25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld Home</b>		ADDRESS <b>6500 York Rd.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and in no event within 72 hours after death.



17226

## CERTIFICATE OF DEATH

17237

1. DECEASED-NAME (Type or print) <b>ELEANORA W. SHAW</b>			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>16</b> Year <b>68</b>			2b. HOUR <b>7:35</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>9-24-85</b>		6. AGE (in years last birthday) <b>83</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore Co. Md.</b>	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Summit Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>522 Inglewood Ave</b>		14. FATHER'S NAME First <b>Christian</b> Middle <b>Michael</b> Last <b>MAISEL</b>		15. MOTHER'S MAIDEN NAME First <b>ELEANORA</b> Middle <b>DILL</b> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>221-44-6376</b>		17. INFORMANT <b>CATONSVILLE, Address MD. 21228</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARCINOMA OF OVARY - METASTASES</b> <b>183.0</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ARTERIO SCLEROTIC HEART DISEASE CHRONIC BRONCHITIS</b>					
19a. DATE OF OPERATION <b>10/22/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF OVARY</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 1968</b> to <b>DEC 16, 1968</b> , that (I) (we) last saw the deceased alive on <b>DEC 16, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John N. Snyder MD</b>		22c. DATE SIGNED <b>12/10/68</b>		22d. PHYSICIAN'S NAME (Type) <b>JOHN N. SNYDER MD</b>		22e. ADDRESS <b>6348 FREDERICK RD. CATONSVILLE MD. 21228</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE <b>12/19/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Maryland</b>	
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DEC 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

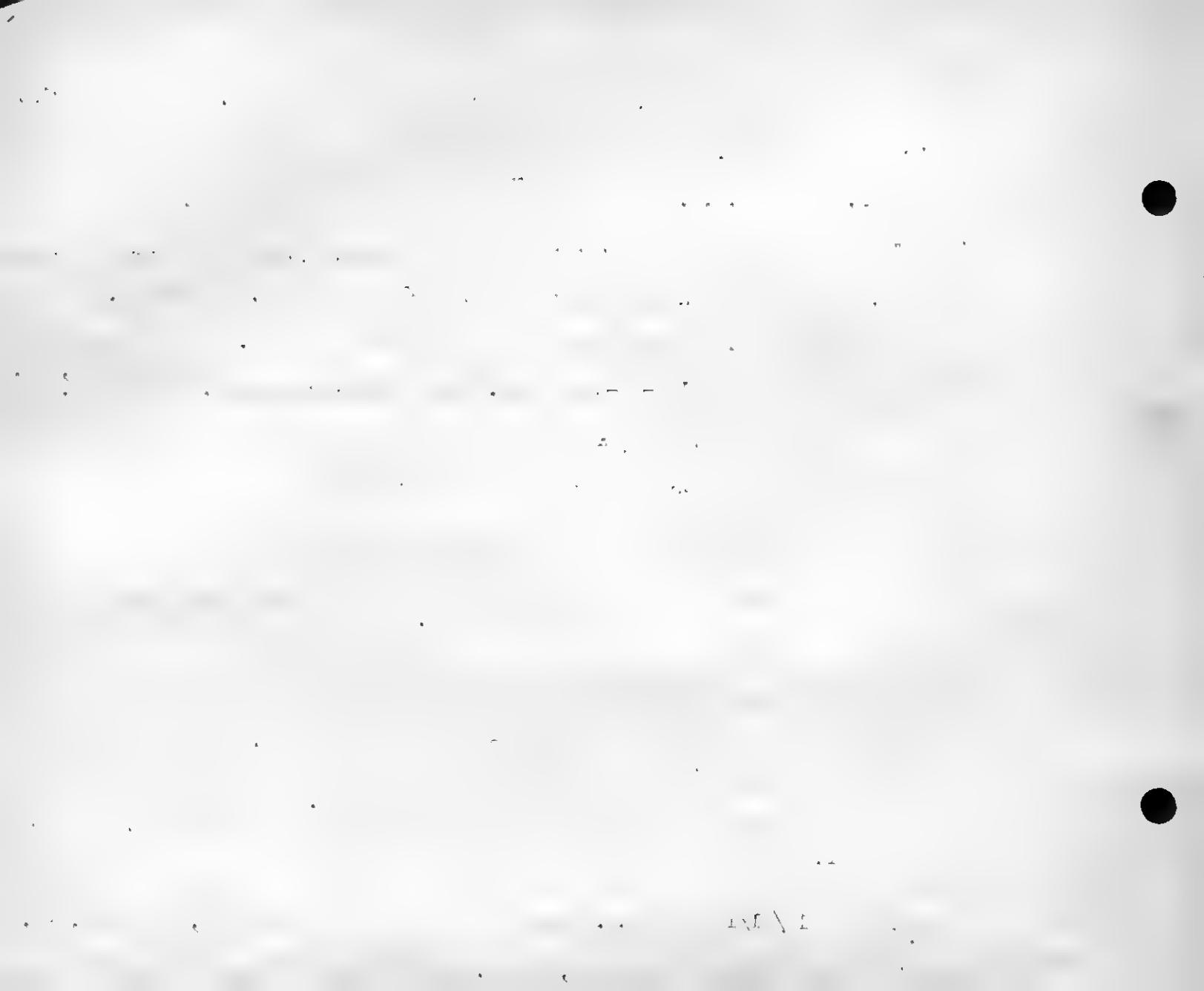
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
CERTIFICATE OF DEATH																				
1 DECEASED NAME (Type or print)			First WAGONER			Middle WADE			Last SHEETZ			2a DATE OF DEATH Month Day Year 12 18 68			2b HOUR 11:50 AM					
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH 5/4/16			6 AGE (In years last birthday) 52 YRS.			7 UNDER YEAR MONTHS DAYS HOURS MIN			8 UNDER 24 HRS HOURS MIN					
7a BIRTHPLACE (State or foreign country) West Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH BALTIMORE COUNTY											
10 CITY OR TOWN OF DEATH FORT HOWARD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSP. FT HOWARD, MD.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PURCHASING AGENT			12b KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE											
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b COUNTRY BALTIMORE			13c CITY OR TOWN BALTIMORE			13d INSIDE CITY LIMITS? Yes <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 8341 CHURCH LANE								
14 FATHER'S NAME First Middle Last WADE SHEETZ			15. MOTHER'S M.A.DEN NAME First Middle Last MAUDE WAGONER																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES			16b. SOCIAL SECURITY NO. WW 11			17 INFORMANT CLINREC. VA HOSP. FT HOWARD, MARYLAND														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PULMONARY EMBOLI DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE, HYPERTENSIVE CARDIOVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DISEASE ARTERIOULAR NEPHROSCLEROSIS																				
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (X) (this hospital) attended the deceased from 12/12/68, 19, to 12/16/68, 19, that (I) (we) last saw the deceased alive on 12/16/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE Rodolfo G. Miros			DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED 12/16/68														
22d PHYSICIAN'S NAME (Type) RODOLFO G. MIRO, M. D.			22e. ADDRESS VAH FORT HOWARD, MARYLAND																	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL			23b DATE 12/20/68			23c NAME OF CEMETERY OR CREMATORY BALTO NATIONAL			23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND											
24. FUNERAL DIRECTOR AMBROSE FUNERAL HOME 1328 Sulphur Spring Road Baltimore, Md.			25a DEC BY REGISTRAR DEC 20 1968			25b REGISTRAR'S SIGNATURE Charles Judge														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First <b>RALPH</b>			Middle <b>F.</b>			Last <b>SHEFFLER</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>28</b> Year <b>68</b>	2b. HOUR <b>9:25 PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>12/18/06</b>		6. AGE (In years last birthday) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY</b>						
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>G.B.M.C.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Motor Freight</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penna.</b>			13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Waynesboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>148 N. Potomac St.</b>			
14. FATHER'S NAME First <b>Daniel</b>			Middle <b>R.</b>		Last <b>Sheffler</b>		15. MOTHER'S MAIDEN NAME First <b>Annie</b>			Middle <b>M.</b>		Last <b>Stoner</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO <b>198-07-4260</b>		17. INFORMANT <b>Mrs. Hazel Sheffler</b>			Address <b>Waynesboro, Pa. 148 N. Potomac St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF LUNG WITH METASTASIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>163X NONE</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <b>December 14, 1968</b> , to <b>Dec. 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 28, 1968</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I)</del> (we) (did) <del>(not)</del> view the body after death.												
22b. SIGNATURE <b>Chang Lin M.D.</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/28/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. Chang Lin</b>						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12/31/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		23d. LOCATION (City or Town) <b>Waynesboro #1, Franklin, Pa.</b>		(County)		(State)		
24. FUNERAL DIRECTOR <b>Harold G. Gove</b>		ADDRESS <b>Waynesboro, Penna.</b>		25a. REC'D BY REGISTRAR <b>DEC 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



17229

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17240

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Mary</b>			First Middle Last <b>Shiptisky</b>			2a. DATE OF DEATH <b>12</b> Month <b>9</b> Day <b>68</b> Year			2b. HOUR <sup>P</sup> <b>12:30</b> M		
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH <b>12/30/06</b>			6. AGE (In years last birthday) <b>61</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Matron</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. G&amp;E.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Balto</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>4411 Parkwood Ave.</b>			14. FATHER'S NAME <b>Peter Charchenko</b>			15. MOTHER'S MAIDEN NAME <b>Natalie</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>no</b>		
16a. SOCIAL SECURITY NO <b>212-05-5389</b>			17. INFORMANT <b>Mr. Steve Shiptisky</b>			17. ADDRESS <b>4411 Parkwood Ave. 21206</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive myocardial infarcts</b> <b>41ng</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>4 x 111</b>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/8</b> , 19 <b>68</b> , to <b>12/9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/9</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Rudiger Breiteneker, M.D.</b>			22c. DATE SIGNED <b>12/9/68</b>			22d. PHYSICIAN'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>			22e. ADDRESS <b>6701 N. Charles Street 21212</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/13/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity Orthodox</b>			23d. LOCATION (City or Town) (County) (State) <b>Elkridge, Md.</b>		
24. FUNERAL DIRECTOR <b>Howard Cty Fun Hm of H. Witzke</b>			25a. REC'D BY REGISTRAR <b>DEC 11 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			25c. DATE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

17230

17241

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MONKTON</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MONKTON.</b>			
c. LENGTH OF STAY IN 1b <b>18 YEARS.</b>				d. STREET ADDRESS <b>IRISH Avenue</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>IRISH AVE</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>William</b> Last <b>SICHARD</b>				4. DATE OF DEATH Month <b>December</b> Day <b>2nd</b> Year <b>1968</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1906</b>		9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William ALEXANDER SICHARD</b>				14. MOTHER'S MAIDEN NAME <b>ANNA BANKERT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1925-1947</b>		17. INFORMANT <b>Mrs. ZENA C. SICHARD</b>		Address <b>MONKTON, Md 21111</b>	
18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>1st Site - Ca. of Pancreas.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>157X</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9 months.</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>December 8, 1967</b> , to <b>December 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>November 29, 1968</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Henry L. McCorkle</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-2-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY L. MCCORKLE MD</b>				22d. ADDRESS <b>Jarrettville Pike, Phoenix Md 21131</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-5-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR <b>Wm Cook-Brooks-Townson Inc.</b>				ADDRESS <b>1000 YORK RD TOWSON, Md. 21204</b>		25a. REC'D BY REGISTRAR <b>DEC 4 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Young</b>			

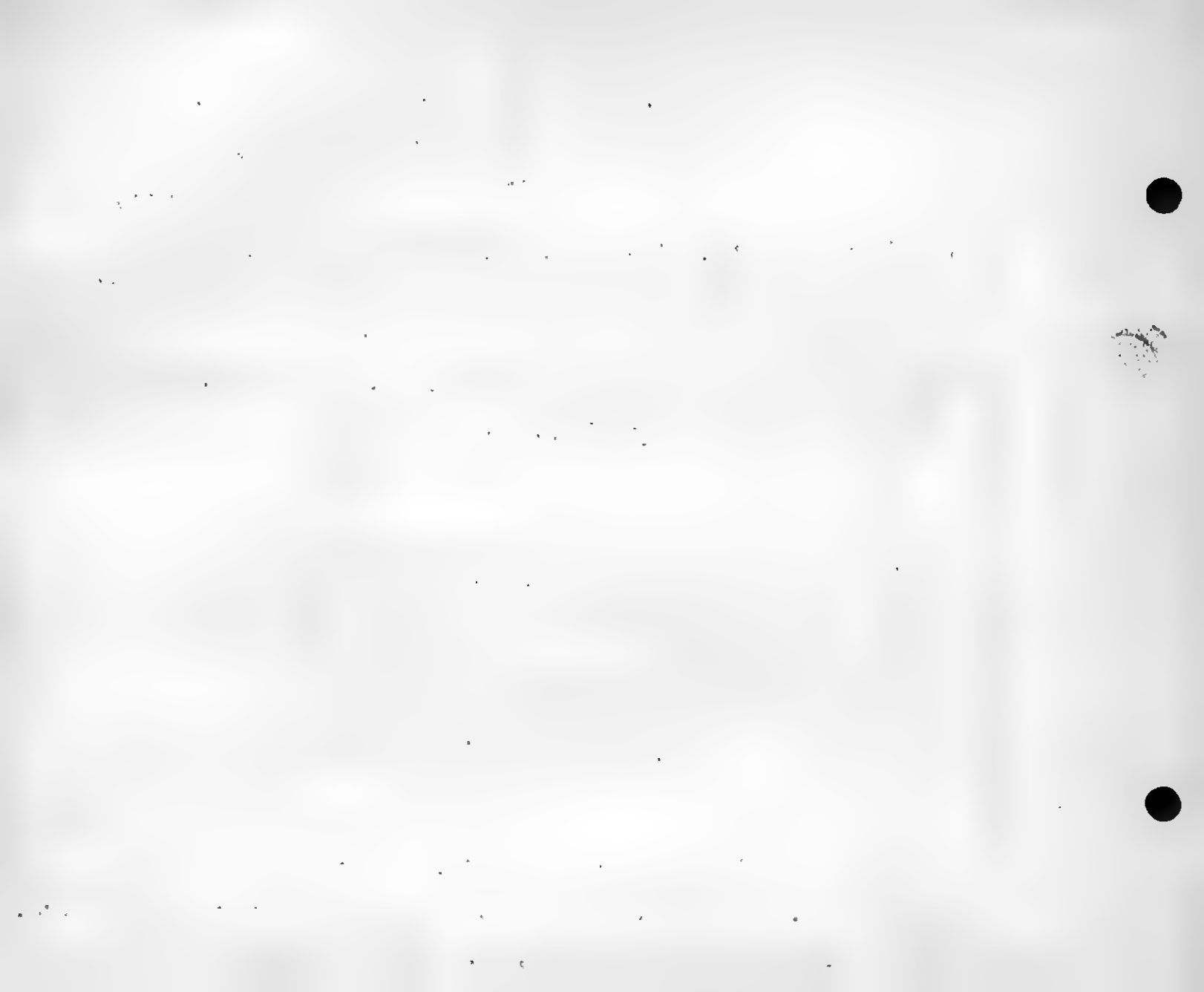




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exempted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>BERNARD LOUIS SIEVERTS</b>			2a. DATE OF DEATH Month <b>12</b> / Day <b>9</b> / Year <b>1968</b>			2b. HOUR <b>10.25 P.M.</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>4/18/1908</b>		6. AGE (in years last birthday) <b>60</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County,</b> Md.			
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Grocer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>115 N. Main St.</b>	
14. FATHER'S NAME First <b>Bernard</b> Middle <b>Sieverts</b> Last <b>Sieverts</b>			15. MOTHER'S M.A.DEN NAME First <b>Anna</b> Middle <b>Grauel</b> Last <b>Grauel</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-10-7492</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE BRONCHITIS, &amp; BRONCHIAL OBSTRUCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>asthma</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>PULMONARY EMPHYSEMA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/8/1968</b> , to <b>12/9/1968</b> , that (I) (we) last saw the deceased alive on <b>12/9/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William Newcomer</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/9/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>				22e. ADDRESS <b>Mount Wilson, Maryland</b>					
23a. BURIAL CREMATION, OR OTHER (Specify) <b>Burial</b>		23b. DATE <b>Dec. 13, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Manchester Carroll Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
RACHEL			SIMON			Month 12 Day 20 Year 68			124 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FEMALE		WHITE		3-11-20		48 YRS.					
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
XXXXXX RICHMOND, VA.			U. S. A.						BALTIMORE MD		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			BALTO. CO. GENERAL HOSPITAL			SALES LADY			LANE BRYANT SHOES		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
MD.			BALTO.		BALTO.				2 ALBESS CT.		
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
ISRAEL CAPLAN				REBECCA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
NO						MR. JACK SIMON, 2 ALBESS CT., APT. 201					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction											
4100 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease										2 YRS	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1946, 19, to 12/19, 1968, that (I) (we) last saw the deceased alive on 12/19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E.S. Kallins M.D.						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12/20/68		
22d. PHYSICIAN'S NAME (Type) E.S. KALLINS M.D.						22e ADDRESS 6000 PARK HILL BLVD BALTIMORE MD 21215					
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
BURIAL			12-22-68		OHEL YAKOV-BETH ISRAEL			BALTIMORE, Maryland			
24 FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD						25a. REC'D BY REGISTRAR DATE DEC 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

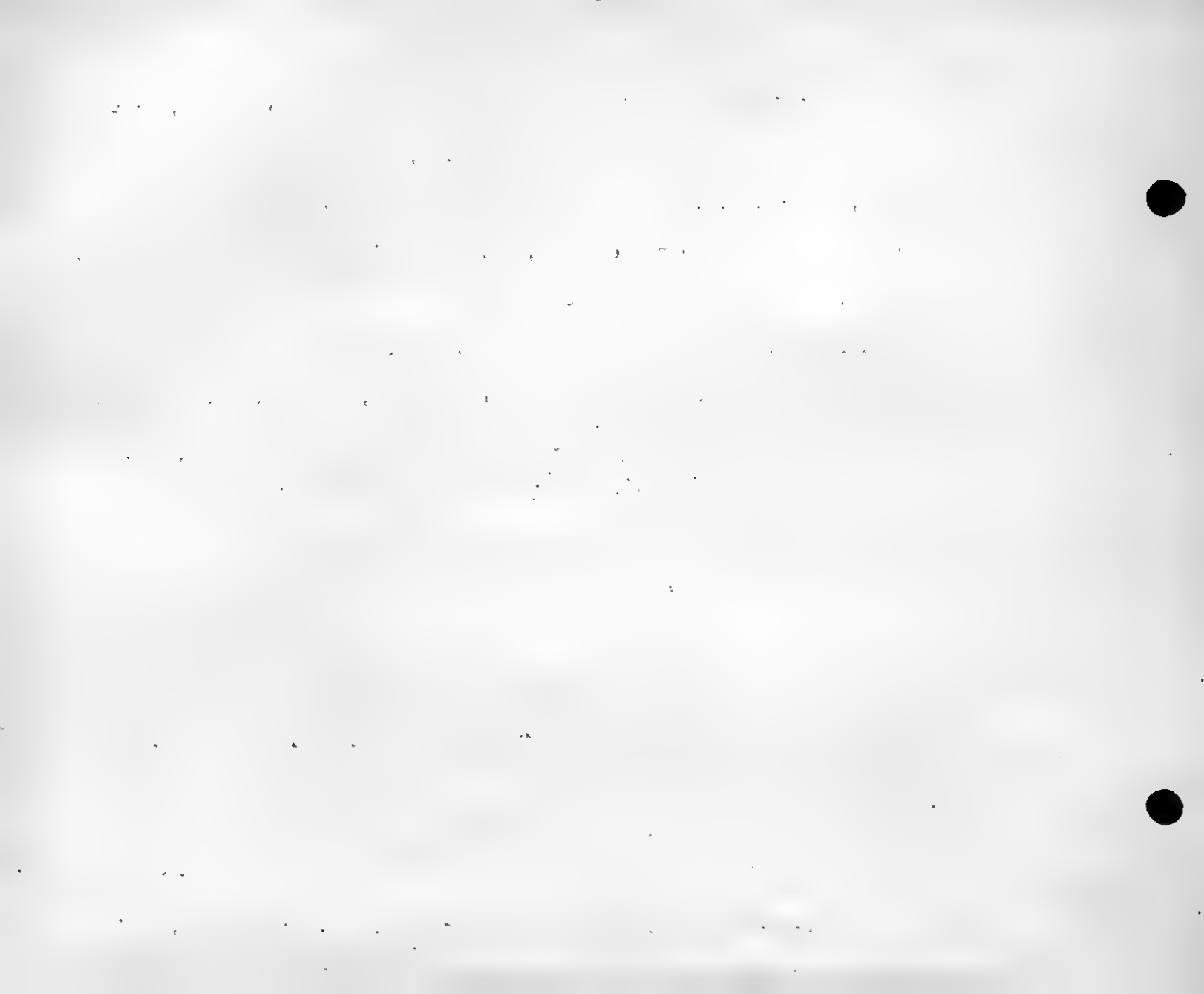
1

17223

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17244

1. DECEASED-NAME (Type or print) <b>Raymond Carroll Slade, Sr.</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>M</b>	
3. SEX <b>M</b>		4. RACE <b>Gauc.</b>		5. DATE OF BIRTH <b>Sept. 4, 1907</b>		6. AGE (In years last birthday) <b>61</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.	
10. CITY OR TOWN OF DEATH <b>Jacksonville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Jarrettsville, Md.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bendix.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Jacksonville</b>		13d. INS. OR CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Charles C. Slade</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Alice Sherer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>219-01 8839</b>		17. INFORMANT Address <b>Myrtle Slade, Monkton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lympho Sarcoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Respiratory Tract</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>last</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Secondary Pneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>November, 1947</b> , to <b>Dec. 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Theodore G. de Quevedo</b>				22c. DATE SIGNED <b>Dec. 10, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Theodore G. de Quevedo</b>				22e. ADDRESS <b>#23 Thornhill Rd. Lutherville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-11-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jacksonville Reform Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Jacksonville, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>				25a. REC'D BY REGISTRAR <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17224

**CERTIFICATE OF DEATH**

17245

1 DECEASED-NAME (Type or print) <b>HENRY A. SLITZER</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>1:30AM</b>			
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5 DATE OF BIRTH <b>SEPTEMBER 27, 1896</b>		6 AGE (n years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS <b>72</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE,</b> Md			
10 CITY OR TOWN OF DEATH <b>TOWSON</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Police</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>			
13a. U.S.A. RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>KINGSVILLE</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>BRADSHAW ROAD #21087</b>	
14 FATHER'S NAME First <b>William</b> Middle <b>Slitzer</b> Last <b>Slitzer</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Van Vene</b> Last <b>Van Vene</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) <b>Yes</b> (If yes give war or dates of service) <b>W.W.I</b>			
16b SOCIAL SECURITY NO <b>212-28-6256</b>			17 INFORMANT Address <b>21087</b> <b>Mrs Irene Slitzer Bradshaw Rd. Kingsville, Md</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive acute myocardial infarction</b> 4, 7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a DATE OF OPERATION <b>4</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>December 23, 1968</b> to <b>December 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>December 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (d d not) view the body after death									
22b SIGNATURE <i>Ines Cilliani</i>		DEGREE <b>M.D.</b>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED <b>12/24/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>		22e ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>12-24-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Balto. Co. Md.</b>		23e	
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road 21236</b>		25a REC'D BY REGISTRAR <b>DEC 30 1968</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove correct papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or print)			First JOSEPH			Middle EDWARD			Last SMITH			20. DATE OF DEATH Month 12 Day 5 Year 68 6:05A M		
3. SEX MALE			4. RACE NEGRO			5. DATE OF BIRTH 12/31/19			6. AGE (In years last birthday) 48 YRS			7. IF UNDER YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign) NORTH CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY			Md		
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY STEEL CO.					
30. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY (Y/N) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1708 W. Lanvale Street		
14. FATHER'S NAME First Middle Last LAMB SMITH			15. MOTHER'S MAIDEN NAME First Middle Last LENA SANDERLIN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO WW II			17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 163X														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (a) (this hospital) attended the deceased from 11/13/68, 19, to 12/5/68, 19, that (b) (we) last saw the deceased alive on 12/5/68, 19, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Ninevah R Aranas M.D.			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED D. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/5/68					
22d. PHYSICIAN'S NAME (Type) NINEVAH R ARANAS, M.D.			22e. ADDRESS VAH FORT HOWARD, MARYLAND											
23a. BURIAL OR CREMATION (Specify)			23b. DATE 12/9/68			23c. NAME OF CEMETERY OR CREMATORY GREENHILL BAPT.			23d. LOCATION (City or Town) (County) (State) Bayboro N.C.					
24. FUNERAL DIRECTOR HAYES FUNERAL HOME, N GILMOR ST, BALTO, MD			ADDRESS			25a. REC'D BY REGISTRAR DEC 6 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION



17228

## CERTIFICATE OF DEATH

17247

1. DECEASED-NAME (Type or print) First Middle Last Louise Contee Smith			2a. DATE OF DEATH 12 Month 26 Day 68 Year			2b. HOUR 8:23 AM		
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 3/1/1912		6 AGE (in years last birthday) 56 YRS.		
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med.Center		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN 12		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5914 Brackenridge Ave.								
14 FATHER'S NAME First Middle Last R. Contee Rose			15 MOTHER'S MAIDEN NAME First Middle Last Nina Didier					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Cleveland Hgts, Ohio Frederick N. Smith, 2477 Overlook Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Widespread retroperitoneal leiomyosarcoma DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Nov. 23, 1968, to Dec. 26, 1968, that (I) (we) last saw the deceased alive on Dec. 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Charles C. Brown, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/26/68		
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M. D.				22e. ADDRESS 6701 N. Charles Street Baltimore Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/28/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co				ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE JAN 2 1969		
				25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR 415 (1)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17248 CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <b>SIDNEY</b>				First Middle Last				2a. DATE OF DEATH Month Day Year <b>DECEMBER 3, 1968</b>			2b. HOUR <b>9:20 PM</b>
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JUNE 14, 1891</b>			6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>					
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Callo. City</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY			13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3445 HARWELL AVE. #21213</b>	
14 FATHER'S NAME First Middle Last <b>William S. Smith</b>				15. MOTHER'S M.A.DEN NAME First Middle Last <b>Mary Jane Haley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <b>no</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <b>-</b>		17. INFORMANT Address <b>Levine S. O'Keefe 3445 Harwell Ave. - 21213</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4221</b> (b) <b>coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from <b>December 2, 1968</b> , to <b>December 3, 1968</b> , that (we) (I) saw the deceased alive on <b>December 3, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Ines Cilliani</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/4/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>				22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12-7-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR <b>John C. Miller Inc 415 Belair Rd. - 21206</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
SARAH			SONKEN			DECEMBER 20, 1968		2:30A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
FEMALE		WHITE				92 YRS.		MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
RUSSIAN		U.S.A.				BALTIMORE		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		MILFORD MANOR NURSING HOME		HOUSEWIFE		AT HOME			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND				BALTIMORE				5507 CADILLAC AVENUE	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b SOCIAL SECURITY NO.			17. INFORMANT			
NO						MR. JERRY SELIGMAN, SEABROOK MOTEL, ROOM 232 9401 COLLINS AVENUE, MIAMI, FLORIDA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rasal cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Yes</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>324x</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19/68</u> to <u>12/20/68</u> , that (I) (we) last saw the deceased alive on <u>12/19/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
<u>Milton Kirsh</u>		<u>12/20/68</u>		MILTON KIRSH		4000 W. NORTHERN PKWY.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		12-22-68		MIKRO KODESH-BETH ISRAEL		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS. 3010 REISTERSTOWN ROAD				DATE DEC 26 1968		<u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Anna J. Southern</b>					2a. DATE OF DEATH Month <b>12</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>6-12-1894</b>		6. AGE (In years last birthday) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS <b>74</b> DAYS <b>74</b> HOURS <b>74</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cockeysville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>24 Hillside Ave.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housekeeper</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>24 Hillside Ave.</b>		13d. INSIDE CITY, MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>24 Hillside Ave.</b>	
14. FATHER'S NAME First <b>Nicholas</b> Middle <b>Beyers</b> Last <b>Beyers</b>				15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Kipp</b> Last <b>Kipp</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <b>212-26-7420A</b>		17. INFORMANT Address <b>Cockeysville, Md.</b> <b>James E. Southern 24 Hillside Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of Breast</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 years</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>174X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>November 1968</b> , to <b>Dec 1968</b> , that (I) (we) last saw the deceased alive on <b>14 December 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Walter T. Kees</b>		DEGREE <b>WALTER T. KEES</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>16 Dec 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22e. ADDRESS <b>Cockeysville Md 21030</b>							
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE <b>12-19-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Stickney, Illinois</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd. Towson, Md</b>		ADDRESS <b>21204</b>		25a. REC'D BY REGISTRAR <b>DEC 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17240										
17251										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) <b>MICHAEL L. SPERANZELLA</b>					2a. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>68</b>					2b. HOUR <b>5:13<sup>PM</sup></b>
3 SEX <b>M</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH <b>5/11/1908</b>		6. AGE (In years last birthday) <b>60</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GR. BALTO. MED. CENTER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Bettler National Brewery</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2701 Goodwood Rd.</b>	
14. FATHER'S NAME First <b>Charles</b> Middle <b>Speranzella</b> Last <b>Fannie</b>					15. MOTHER'S MAIDEN NAME First <b>DiSisi</b> Middle <b>DiSisi</b> Last <b>DiSisi</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Margaret Speranzella</b>			Address <b>same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>FULMINATING BRONCHOPNEUMONIA</b>										
201X DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY HODGKIN'S DISEASE</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
201X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>12-22</b> , 19 <b>68</b> , to <b>12-24</b> , 19 <b>68</b> , that (I) <del>(we)</del> saw the deceased alive on <b>12-24</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(we)</b> (did not) view the body after death.										
22b. SIGNATURE <i>Manuel V. Gatchalian</i>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-24-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. MANUEL V. GATCHALIAN</b>					22e. ADDRESS					
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE <b>12/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>					25a. REC'D BY REGISTRAR <b>DEC 26 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17211

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17252

1 DECEASED NAME (Type or Print) <b>GEORGE WISE SPITTLE</b>			First Middle Last			2a DATE KNOWN OF DEATH Month Day Year <b>December 31 1968</b>			2b HOUR OF DEATH M <b>3:40</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Dec. 10, 1895</b>	6. AGE (In years last birthday) <b>73 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year <b>December 31 1968</b>			2d HOUR M <b>4:45</b>	
7a BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b>			Md			
10. CITY OR TOWN OF DEATH <b>Anneslie Balto. Co.</b>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>744 Overbrook Rd.</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Guard</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>			
13a USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			13e STREET AND NUMBER <b>744 Overbrook Rd.</b>			
14. FATHER'S NAME <b>Griffith Spittle</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Anna Reighter</b>			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>215-01-1967</b>			17. INFORMANT <b>Mrs. Agnes B. Spittle</b>			ADDRESS <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4107</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4107</b>												
19a. DATE OF OPERATION <b>4-1-68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Dr. Charles F. O'Donnell</b>			EXAMINER'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <b>12/31/68</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>1-3-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md.</b>						25a. REC'D BY REG. STRAR DATE <b>JAN 6 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15  
30M RE 150

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
17212 CERTIFICATE OF DEATH										17253		
1 DECEASED-NAME (Type or print) First Middle Last Gilbert Clemm Spurrier						2a. DATE OF DEATH 12 Month 6 Day 68 Year			2b. HOUR M			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH 7/24/1896			6 AGE (in years last birthday) 72 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md						
10. CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Police Balto. City			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3003 Woodhome Ave.			
14. FATHER'S NAME First Middle Last Charles Spurrier				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Clemm								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no				16b. SOCIAL SECURITY NO. 212-09-2950A		17. INFORMANT Address Elsie M. Spurrier same						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>412.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>422.1</u> <u>Bronchopneumonia</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> , 19 <u>68</u> , to <u>12/6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Rudiger Breiteneker</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/6/68				
22d. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D.						22e. ADDRESS 6701 N. Charles Street						
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 12/9/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park				23d. LOCATION (City or Town) Balto. Md.		(County) (State)		
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.						25a. REC'D BY REGISTRAR DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17213

17254

1. DECEASED NAME (Type or print) First Middle Last <b>ANDREY ELMER STACK</b>			2a. DATE OF DEATH Month Day Year <b>12 27 68</b>		2b. HOUR <b>5:15A. M.</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>11/12/06</b>	6. AGE (In years last birthday) <b>62</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b> Md		
10. CITY OR TOWN OF DEATH <b>ROCKDALE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3508 ROLLING RD.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SALESMAN</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>ROCKDALE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>3508 ROLLING RD.</b>	
14. FATHER'S NAME First Middle Last <b>LUTHER EMERSON STACK</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>EDITH NORTH</b>			
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO <b>214-18-5121</b>	17. INFORMANT Address <b>WIFE - MRS. AGNES STACK 3508 ROLLING RD. BALTIMORE, MD 21207</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF COLON WITH METASTASES.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 YEARS.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 11, 1964</b> , to <b>DEC 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>DEC 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edwin L. Pierpont, M.D.</b>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>12/27/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>		22e. ADDRESS <b>8204 LIBERTY RD - BALTIMORE, MD 21207</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-30-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD</b>	
24. FUNERAL DIRECTOR <b>Robert Strong</b>		ADDRESS <b>307 W North Ave.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



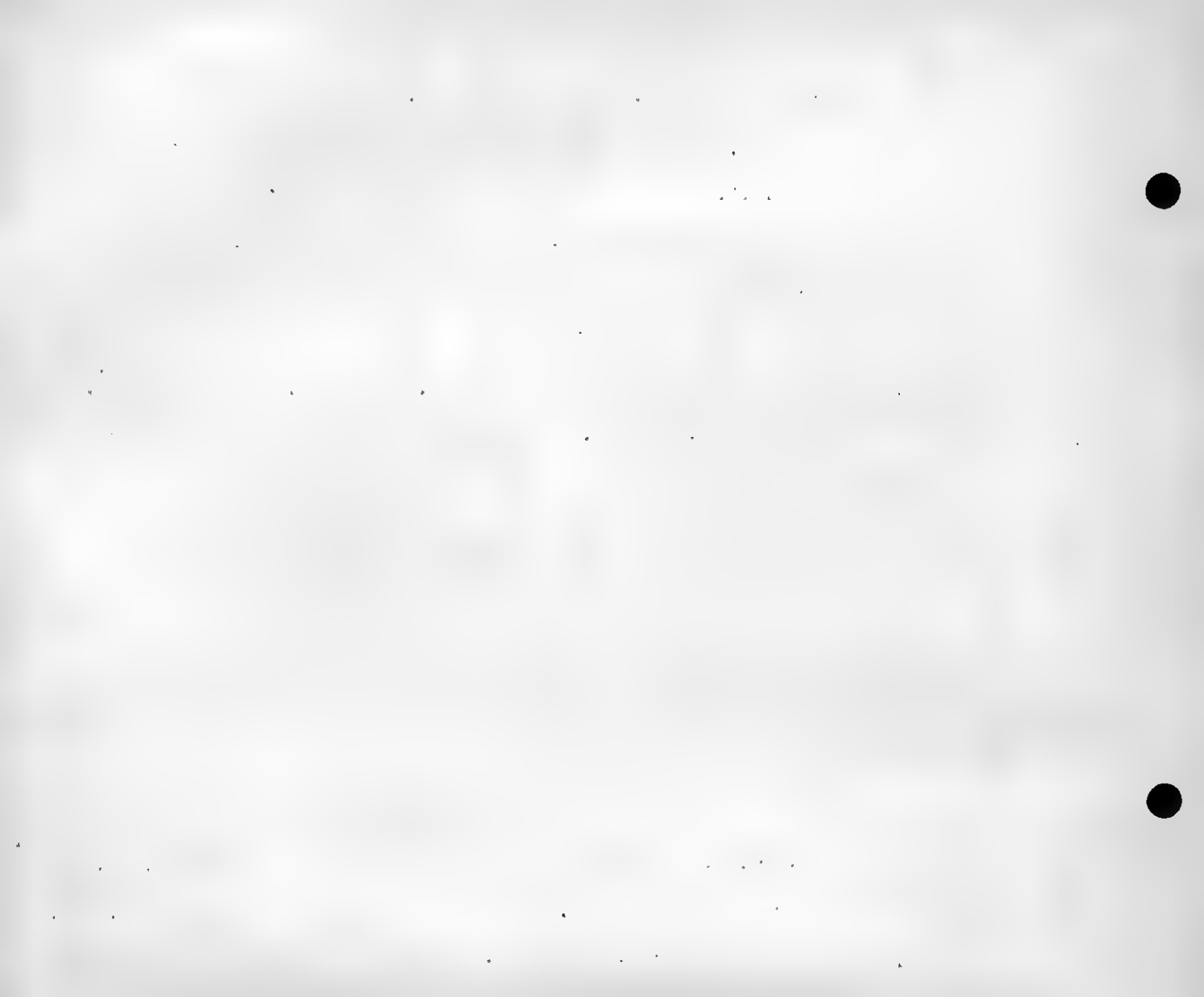
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17255

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
Mallory		S.		Stant, Sr.	Dec 19		19	68	10	M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year
Male	White	Oct. 20, 1896	72 YRS	MONTHS	DAYS	Dec 19		19	68	11
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Virginia		U.S.A.				Baltimore		Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Dundalk			7305 Kirtley Road			Self-Employed - Boat Captain				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			3d INSIDE CITY (If 157)	
Maryland			Baltimore			Dundalk			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER				
William			Amenda			7305 Kirtley Road				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS	
No			214-30-8231			(SON)			Dundalk, Md. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease										
4129 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Diabetes Mellitus										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. P.M. 19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED				
Melvin B. Davis, MD						12/19/68				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			6800 Mornington Rd.				
Melvin B. Davis, MD						Dundalk, Md. 21222				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)	
Removal & Burial			12/23/68			Sanford Cemetery			Sanford, Accomack Co. Va.	
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
John J. Duda, 7922 Wise Avenue, Dundalk, Md.						DEC 23 1968		K. C. Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 49

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>ANNA MAE STEINER</b>						2a. DATE OF DEATH Month Day Year <b>December 21 1968</b>			2b. HOUR Min <b>94</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Feb. 6, 1894</b>			6. AGE (In years last birthday) <b>74</b> YRS			7. UNDER 1 YEAR MONTHS DAYS <b>1</b> <b>1</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>Towson</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA St. Joseph's Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1215 Malbay Dr. 21093</b>	
14. FATHER'S NAME First Middle Last <b>John Miller</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Lucy</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-01-1944</b>		17. INFORMANT <b>Mrs. Roy L. Snow</b>				Address <b>same # 13 E</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>											
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <b>GENERALIZED ARTERIO SCLEROSIS</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4200 <b>DIABETES MELLITUS</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 30, 1956</b> to <b>Dec. 21, 1968</b> , that (I) <del>was</del> last saw the deceased alive on <b>DEC. 16 1968</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>(did)</del> (did not) view the body after death.											
22b. SIGNATURE <b>T. C. Siwinski</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Dec. 23, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Thaddeus C. Siwinski</b>						22e. ADDRESS <b>206 W. Pennsylvania Ave.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-24-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson Inc. 1050 York Rd.</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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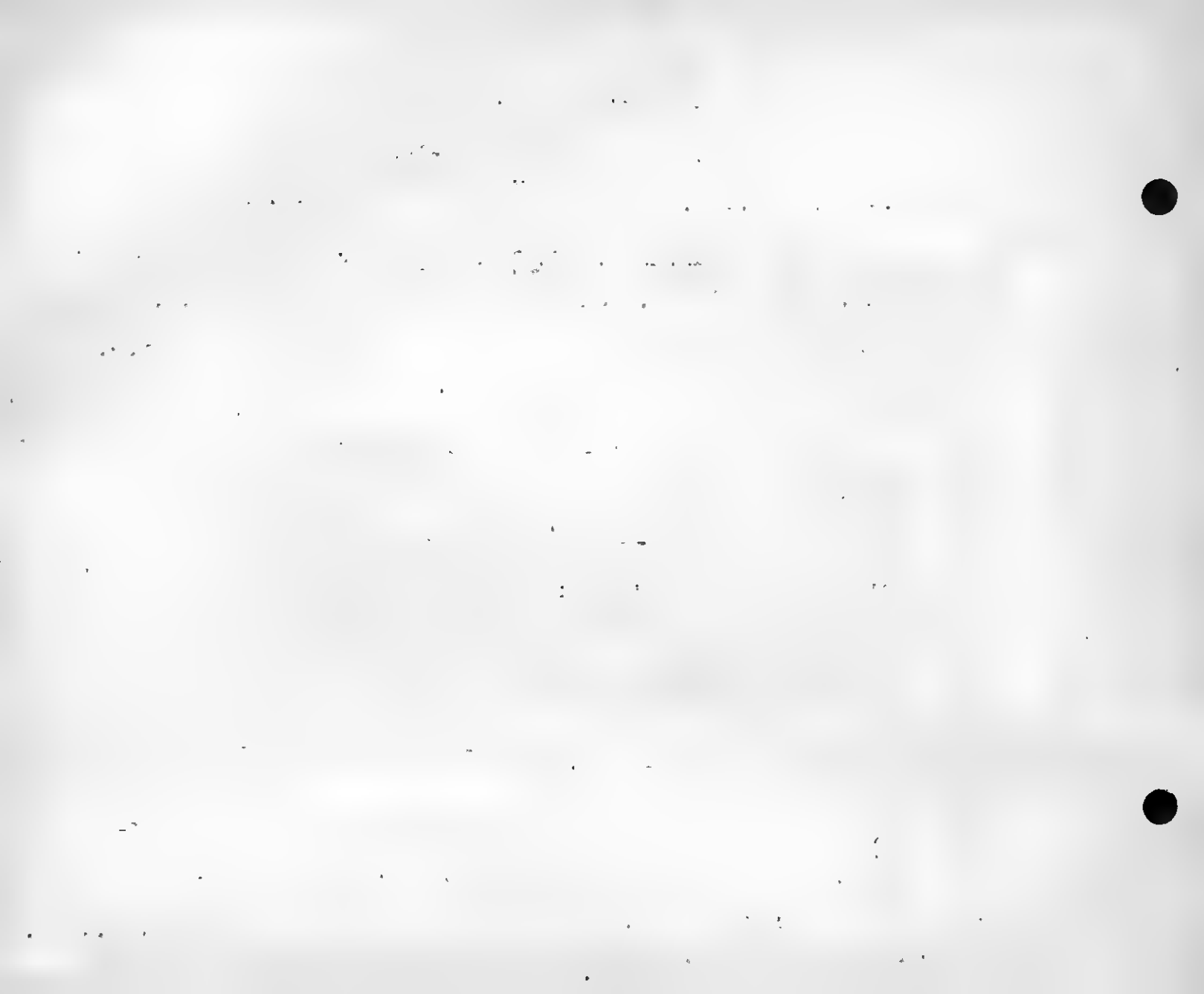
17216

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17257

1. DECEASED-NAME (Type or print) <b>ELAINE VANDENBERG STOKES</b>			2a. DATE OF DEATH <b>12</b> Month <b>25</b> Day <b>68</b> Year			2b. HOUR <b>10:38</b> P			
3. SEX <b>FEMALE</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>3-14-1899</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Balto Co., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GRTR. BALTO. MED. CENTER</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto. Glencoe</b>		13c. CITY OR TOWN <b>Sparks P.O.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME First Middle Last <b>Henry Murdoch Lord</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Engalina Vandenberg</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>John Austen Stokes (Same)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST WITH PULMONARY EDEMA</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4221</b> (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED VASCULAR DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>BRONCHOPNEUMONIA AND CARDIAC ARRHYTHMIA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-24</b> , 19 <b>68</b> , to <b>12-25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gihan Tennekoan</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-25-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. GTHAN TENNEKOON</b>				22e. ADDRESS <b>6701 NORTH CHARLES STREET</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel</b>		23d. LOCATION (City or Town) (County) (State) <b>Glencoe, Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>				ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. Jones</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <b>(Known as Marie) Maryanna K. Strappelli</b>			2a DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>68</b>			2b HOUR <b>5.15 PM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>11-25-11</b>		6 AGE (In years last birthday) <b>57</b> YRS.		7c UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4911 E. Federal St.-21205</b>	
14 FATHER'S NAME First <b>James</b> Middle <b>Kruszynski</b> Last <b>Kruszynski</b>			15. MOTHER'S M A DEN NAME First <b>Frances</b> Middle <b>Rosinski</b> Last <b>Rosinski</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO <b>213-10-3493</b>		17. INFORMANT <b>Linda Woods, dght., 4912 Forrest View Charles A. Strappelli-husband, above Ave.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>202X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-25-</b> , 19 <b>68</b> , to <b>12-29-</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-29-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jaime Punzalan</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-29-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Jaime Punzalan M.D.</b>				22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/2/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		23d. LOCATION (City or Town) <b>Balto., Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home</b> <b>3331 Brehms Lane</b>				ADDRESS <b>21213</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>First</b> <b>Anne</b> <b>Middle</b> <b>M.</b> <b>Last</b> <b>Streeter</b>			2a. DATE OF DEATH <b>December</b> <b>Month</b> <b>2nd</b> <b>Day</b> <b>1968</b> <b>Year</b> <b>2.30P M</b> <b>2b. HOUR</b>						
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>19 Dec. 1881</b>		6 AGE (In years last birthday) <b>98</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County Md.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holly Hill Nursing Home 531 Stevenson Lane</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>home</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Balto. Co.</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>531 Stevenson Lane</b>	
14. FATHER'S NAME <b>First</b> <b>John</b> <b>Middle</b> <b>Hannon</b> <b>Last</b>			15. MOTHER'S MAIDEN NAME <b>First</b> <b>Mary</b> <b>Middle</b> <b>Tynan</b> <b>Last</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>none</b>			16b. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>Dorothy Ohlson, P.O. Box 275, Glen Burnie</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>4407</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/2, 1968</b> , to <b>12/2, 1968</b> , that (I) (we) lost the deceased alive on <b>12/2, 1968</b> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Laurence C. Post M.D.</b> DEGREE <b>MED</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>12/2/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Laurence C. Post, M. D.</b>				22e. ADDRESS <b>6805 York Road, Balto. Md. 21212</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/3/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City or Town) <b>Fort Myers, Va.</b> (County) (State)			
24. FUNERAL DIRECTOR <b>Singleton Funeral Home/Glen Burnie, Md.</b> ADDRESS <b>R.P. Lane</b>				25a. REC'D BY REGISTRAR <b>DEC 4 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse wrapper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17219		CERTIFICATE OF DEATH						17260	
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M
THOMAS BARNETT SUMMERS						December 29 1968			
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		6-28-1898			75 YRS.		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore, Maryland		USA				Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hosp tal give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Towson			St. Joseph's Hospital						CAB
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland					Baltimore		6166 Parkway Drive		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
YES			216-03-5131		T. TUCKER		6166 PARKWAY DR		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholic cirrhosis</u> <u>5710</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5811</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic Cardio-Vascular Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or RFD No.		City or Town		County	State
22a. I certify that (I) (the hospital) attended the deceased from <u>Dec. 21</u> , 19 <u>68</u> , to <u>Dec 29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Beatriz P. Dizon</u>					DEGREE	ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 12-29-68		
22d. PHYSICIAN'S NAME (Type) Dr. Beatriz Dizon					22e. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL		12/68		BALTO. NATL.			BALTO. MD.		
24. FUNERAL DIRECTOR J.G. CONNELLY SONS					ADDRESS 300 MACE		25a. REC'D BY REG. STRAR DATE JAN 1 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove common papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Diana</b>			First <b>S.</b> Middle <b>S.</b> Last <b>Swegon</b>			2a. DATE OF DEATH <b>Dec.</b> Month <b>12</b> , Day <b>1968</b>			2b. HOUR <b>M</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 19, 1928</b>		6. AGE (In years lost birthday) <b>40</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2808 Garnet Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2808 Garnet Road</b>	
14. FATHER'S NAME First <b>William</b> Middle <b>D.</b> Last <b>Rust</b>			15. MOTHER'S MAIDEN NAME First <b>Annie</b> Middle <b>Wyatt</b> Last <b>Wyatt</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, none unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>217-26-0024</b>		17. INFORMANT <b>Mr. Daniel F. Swegon</b>		Address <b>(Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>syn</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>26 Sept</b> , 19 <b>58</b> , to <b>12 Dec</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6 Dec</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Howard Goodman</b>		22c. PHYSICIAN'S NAME (Type) <b>Howard Goodman</b>		22d. ADDRESS <b>8604 Hampden Rd</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED <b>12 Dec 68</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/14/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>			





✓ 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17251										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17262																																							
1. DECEASED-NAME (Type or print)										2. DATE OF DEATH										2b HOUR																																							
WALTER TABOR										Month 12 Day 28 Year 68										8:20A M																																							
3 SEX MALE										4 RACE WHITE										5. DATE OF BIRTH 4/3/04										6 AGE (In years last birthday) 64 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
7a BIRTHPLACE (State or foreign country) WEST VIRGINIA										7b CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH BALTIMORE COUNTY Md																													
10 CITY OR TOWN OF DEATH FORT HOWARD										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ENGINEER										12b KIND OF BUSINESS OR INDUSTRY CAN COMPANY																													
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm. ssion) STATE MARYLAND										13b COUNTY BALTIMORE										13c CITY OR TOWN BALTIMORE										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 3312 Bero Road 21227																			
14 FATHER'S NAME First Middle Last ROBERT TABOR										15. MOTHER'S MA DEN NAME First Middle Last JANE JACKSON										16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES-PT 12/26/23 -11/14/26 217 03 81 98										16b SOCIAL SECURITY NO 12/26 217 03 81 98										17 INFORMANT CLIN. RECORDS, VA HOSP. FT HOWARD, MD.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS																																																	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LUNG 1621										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) DUE TO, OR AS A CONSEQUENCE OF																																																	
										(c) DUE TO, OR AS A CONSEQUENCE OF																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (X) (this hospital) attended the deceased from 12/4/68, 19, to 12/26/68, 19, that (H) (we) last saw the deceased alive on 12/26/68, 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																																																											
22b SIGNATURE J. D. Talbert, M.D.										DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										22c DATE SIGNED 12/26/68																																							
22d PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.										22e ADDRESS VAH FORT HOWARD, MARYLAND																																																	
23a BURIAL, CREMATION, REINTERMENT BURNED										23b DATE 12-30-68										23c NAME OF CEMETERY OR CREMATORY CREST LAWN CEMETERY										23d LOCATION (City or Town) (County) (State) BALTIMORE, MD.																													
24. FUNERAL DIRECTOR										ADDRESS HUBBARD FUNERAL HOME 4107 WILKINS AV. BALTO. MD.										25a REC'D BY REGISTRAR DATE DEC 30 1968										25b REGISTRAR'S SIGNATURE J. Charles Judge																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17252					17263				
1 DECEASED NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year			2b. HOUR MIN.	
ELIZABETH B. TAGART					DECEMBER 20th, 1968			8:45M	
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		6-16-1883		82 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Italy		U.S.A.				Baltimore County		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Lutherville, Md.		COLLEGE MANOR NURSING HOME		COMPARISON SHOPPER					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSURE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
WASHINGTON, D.C.								ROOM 1011 HOTEL	
14 FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
WATLERN PALMER BAGGALEY					OLGA ALPIERI UCCELLI				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no		unknown		DR. PALMER WILLIAMS, OWINGS MILLS, MD. 21117					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C-V-A</u>								12 hours	
4260 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterio-sclerotic + hypertensive</u>								20 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from <u>May 12, 1968</u> to <u>Dec 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 10, 1968</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Palmer H. Williams MD</u>					22c. DATE SIGNED <u>Dec 20, 1968</u>		22d. PHYSICIAN'S NAME (Type) <u>PALMER H. WILLIAMS</u>		
					22e. ADDRESS <u>LANSTON RD. OWINGS MILLS, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Interment</u>		<u>Dec 21, 1968</u>		<u>Stanton Park Cemetery</u>		<u>Baltimore Md</u>			
24. FUNERAL DIRECTOR <u>Frank H. Howell, Pikesville, Md</u>					25a. REC'D BY REGISTRAR <u>DEC 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

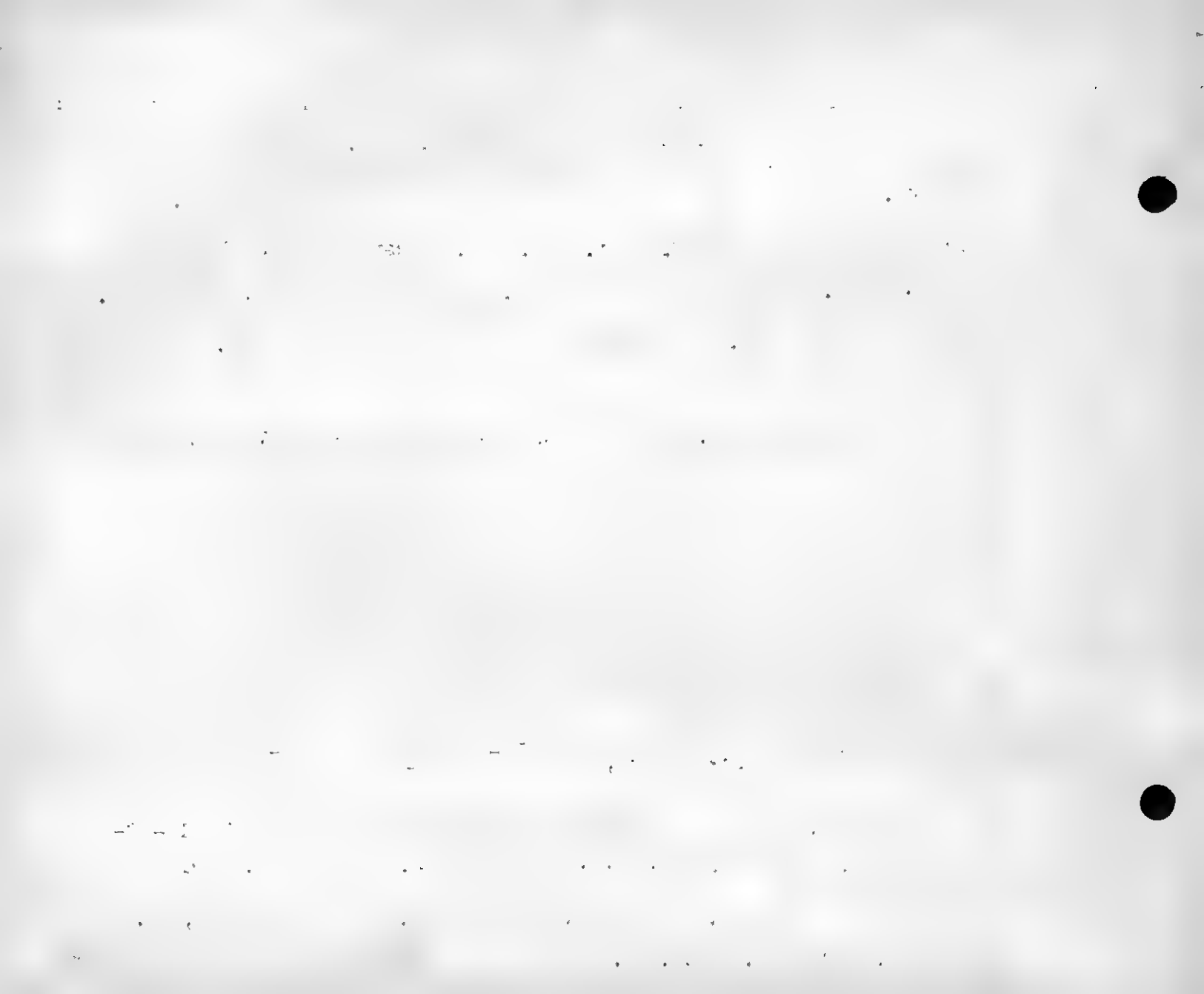
100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, may the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17253 CERTIFICATE OF DEATH 17264									
1. DECEASED NAME (Type or print) First Middle Last <b>EARLE WILLIAM TAYLOR</b>					2a. DATE OF DEATH 12 Month 27 Day 68 Year 2b. HOUR 5:15 P.M.				
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>April 20, 1904.</b>		6. AGE (In years last birthday) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE Co.</b> Md			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. GEN.</b>		12a. USUA. OCCUPATION (Kind of work done during most of work na life, even if retired) <b>Guard-Maritime Police</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1555 Abbottston St.</b>			
14. FATHER'S NAME First Middle Last <b>William F. Taylor</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Grace M. Sparks</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of LEFT LUNG with GENERALIZED METASTASIS</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <b>1</b> (this hospital) attended the deceased from <b>12-26</b> , 19 <b>68</b> , to <b>12-27</b> , 19 <b>68</b> , that <b>1</b> (we) last saw the deceased alive on <b>December 27, 1968</b> , and that in (my) <del>your</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> (did not) <del>not</del> view the body after death.									
22b. SIGNATURE <b>Mary O. Lim, M.D.</b> DEGREE					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-27-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>DR. MARY O. LIM M.D.</b>					22e. ADDRESS <b>6701 N. CHARLES ST. 21204</b>				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <b>12/31/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>					25a. RECEIVED BY REGISTRAR DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



# FOR STATE HEALTH DEPT.

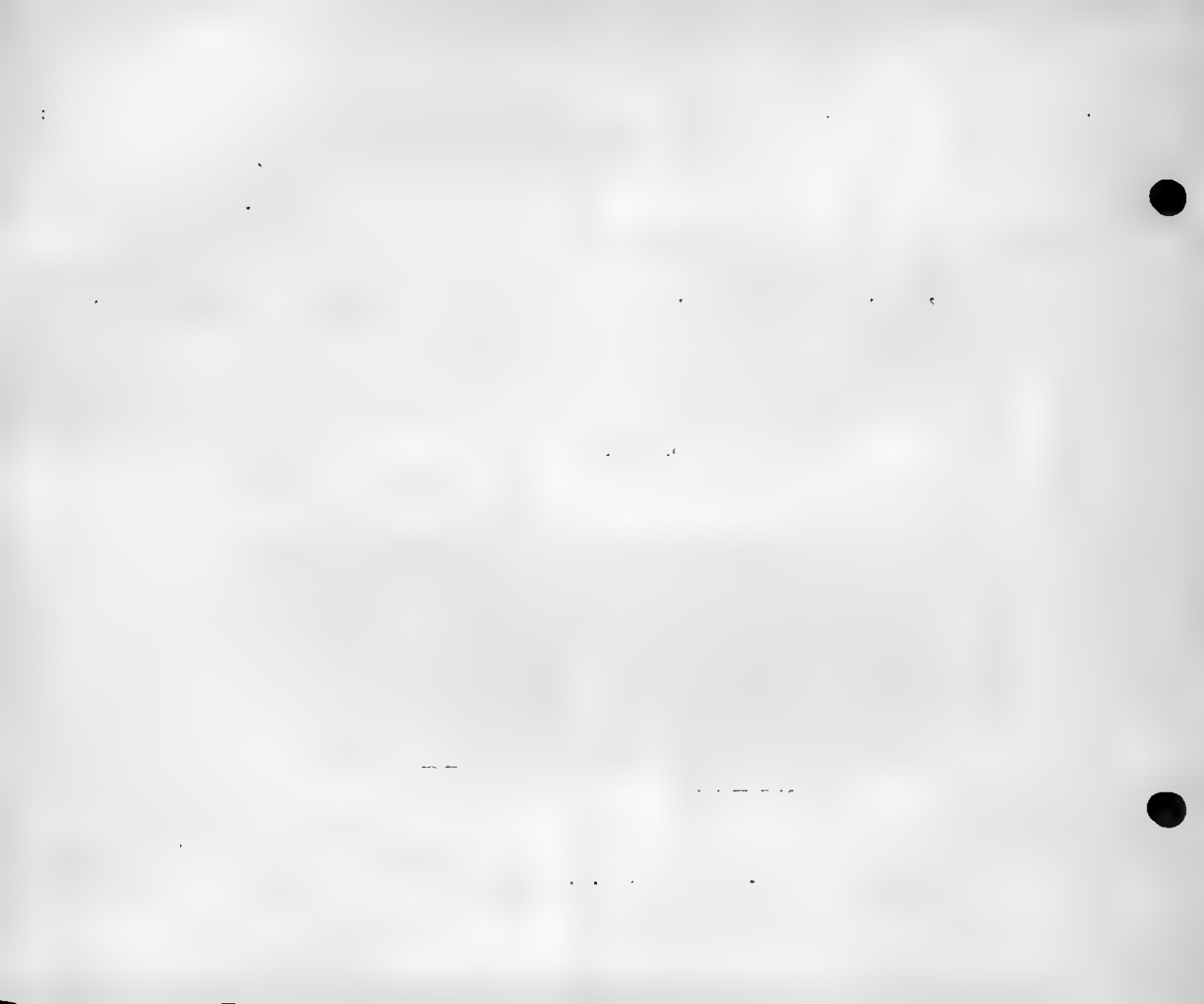
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PMS-Page 5" may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 10 Film 108  
1/13/69 kk  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
1725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17265

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
HERBERT C			TEGEDER			12 28 1968			2:40		
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR		
Male	White	2/14/1915	53 YRS.			Dec. 28 1968			2:40		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Balto.			Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
1. Carney		1920 Mountain Ave.							Balto. Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Balto.						1920 Mountain Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Herbert C. Tegeder			Anne Floyd								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			
no					family records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4-11</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED							
<u>Ronald N. Kornblum</u>		Ronald N. Kornblum, M.D.		12/28/68							
23a. BURIAL, CREMATION, REMOVA. (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
burial		12/31/68		Moreland Memorial		Baltimore County, Md.					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE			
C. F. EVANS & SON 8802 Harford Road						DATE DEC 30 1968		<u>Charles Judge</u>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 23 Film 3, 07 12/23/68 MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>17255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17266</div>											
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson, Md.</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21093</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Baltimore Medical Center</b>						d. STREET ADDRESS <b>1002 Kenilworth Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Helen Shirley Thomas</b>			First Middle Last			4 DATE OF DEATH <b>12 10 19 68</b>			Month Day Year		
5 SEX <b>Female</b>		6 COLOR OR RACE <b>Cauc.</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Sept. 24, 1931</b>		9 AGE (In years last birthday) <b>37 yrs</b>		10 UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work no file, even if retired) <b>Prof. of Political Science. Loyola Col.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Md.</b>		11 BIRTHPLACE (State or foreign country) <b>USA</b>			12 CITIZEN OF WHAT COUNTRY?		
13 FATHER'S NAME <b>Frederick Thomas</b>						14. MOTHER'S MAIDEN NAME <b>Helen E. Worthington</b>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>				16 SOCIAL SECURITY NO <b>218 28 6737</b>		17 INFORMANT <b>DAVID R. COHAN, atty. 10 Light St. 21202</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>3701</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Lower nephron nephrosis</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>591 Fatty liver</b>										19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <b>12/11/68</b>		
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>12/11/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>					
24 FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC. Baltimore Md.</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 18 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17267	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First JOHN		Middle R.		Last THOMAS		2a. DATE KNOWN OF DEATH		2b. HOUR
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7c. DATE PRONOUNCED DEAD		7d. HOUR
MALE			NEGRO		3/4/06		62 YRS		12 9 1968		15
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND			U.S.A.						BALTIMORE COUNTY, Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
FORT HOWARD			VET. ARM. HOSPITAL						LABORER		CONSTRUCTION
13a. U.S.A. RESIDENCE (Where deceased lived, admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
MARYLAND						BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		704 E. BALTIMORE STREET
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
DANIEL			THOMAS			ALBERTA			KELLY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
YES			219 03 18 06			CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter on y one cause per line (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Smoke + Soot Inhalation</u>										10 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
1161 line											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			6/29/68			Inhaled Smoke and hot fire					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (at home, farm, street, factory, place of business, etc.)			21f. LOCATION (Street or R.F.D. No., City or Town, County, State)					
			At home			704 E. Baltimore St - Fort Md					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER						22b. DATE SIGNED		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER						12/9/68		
MELVIN B. DAVIS, M. D.			DEPUTY MEDICAL EXAMINER						12/9/68		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			12-12-68			BALTIMORE NATIONAL			BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
E. O. Wilson			WILSON FUNERAL HOME			DEC 17 1968			Charles Judge		
			2004 ORLEANS ST. BALTIMORE, MD.								



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17257

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print) <b>Margaret</b>			First <b>Mm</b>			Middle <b>Thomas</b>			Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Dec</b> Day <b>12</b> Year <b>1968</b>			2b HOUR <b>6:30</b>														
3 SEX <b>F</b>			4 RACE <b>W</b>			5 DATE OF BIRTH <b>4/8/82</b>			6 AGE (in years on birthday) <b>86</b> YRS			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>			2c DATE PRONOUNCED DEAD Month <b>Dec</b> Day <b>12</b> Year <b>1968</b>			2d HOUR <b>M</b>								
7a BIRTHPLACE (State or foreign country) <b>South Wales</b>						7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9 COUNTY OF DEATH <b>Baltimore</b>											
10 CITY OR TOWN OF DEATH <b>Randallstown</b>						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. Co. General</b>						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b KIND OF BUSINESS OR INDUSTRY											
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>MD.</b>						13b COUNTY <b>Balto</b>						13c CITY OR TOWN <b>BALTO</b>						13d INSIDE CITY, IN 157 YES <input type="checkbox"/> NO <input type="checkbox"/>						13e STREET AND NUMBER <b>Box 447 Dogwood Rd.</b>					
14 FATHER'S NAME First <b>George</b> Middle <b>Phillips</b> Last						15 MOTHER'S MAIDEN NAME First <b>Mr. George Phillips</b> Middle <b>6381 Yale Ave.</b> Last						16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO <b>220-14-3352</b>						17. INFORMANT <b>Mr. George Phillips</b> ADDRESS <b>6381 Yale Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>486x</b> <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No <b>City or Town</b> <b>County</b> <b>State</b>																	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <b>J. Nelson McKay</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b DATE SIGNED <b>Dec 12, 1968</b>																	
EXAMINER'S NAME (Type) <b>J. Nelson McKay, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
ADDRESS (Street, city, town, or county)						23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b DATE <b>12/16/68</b>																	
23c NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>						23d LOCATION (City or Town) <b>Baltimore, Maryland</b> (County) (State)						23e REC'D BY REGISTRAR <b>DEC 13 1968</b>																	
24 FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave., 21229</b> ADDRESS						25a REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>						DATE <b>DEC 13 1968</b>																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>Mary Elizabeth Thomas</b>						2a. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>68</b>			2b. HOUR AM <b>8:30</b> M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 28, 1870</b>			6. AGE (In years last birthday) <b>97</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign) <b>Montgomery Co. Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md					
10. CITY OR TOWN OF DEATH <b>Towson, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sheppard &amp; Enoch Pratt Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Dietician</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2001 Park Avenue</b>		
14. FATHER'S NAME First Middle Last <b>Edward Porter Thomas</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary - Bentley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>no</b>			16b. SOCIAL SECURITY NO <b>128-16-8399</b>			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>											
4127 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b>											
(c) <b>(and) influenza</b>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>											
20 yrs.											
3 wks.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 3, 1957</b> , to <b>Dec. 22, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Paul Rodenhauer, Jr. M.D.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Dec. 22, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Paul Rodenhauer, Jr. M.D.</b>						22e. ADDRESS <b>Sheppard Pratt Hospital, Towson, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Johns Hopkins Hospital</b>				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. Towson, Md.</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

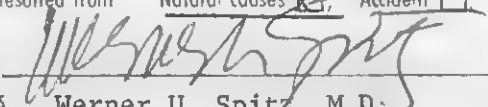
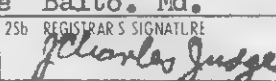
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17259

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17270

1 DECEASED NAME (Type or Print)			First	Middle	Lost	2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b HOUR
JOSEPH			FRANK	TREMPER				19	M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
male	white	Oct 11, 1908	60 YRS					December 31, 19 68	10:00 A. M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.						Baltimore			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
Essex		Kenthly Road			Well digger				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Baltimore		Essex				Kenthly Road	
14 FATHER'S NAME			First	Middle	Lost	15 MOTHER'S MAIDEN NAME			First Middle Lost
Leonard J			Tremper			Margaret			Koch
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
no					Agnes Gerst 4446 India Ave 36				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Alcoholic Intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>22 years</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary Tuberculosis, Caseous, Cavitory</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			22b. DATE SIGNED			
			Werner U. Spitz, M.D.			12/31/68			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			1/2/69		Parkwood Cem.		Parkville Balto. Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE	
Lassahn Funeral Home 7401 Belair Rd.						JAN 3 1969			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Alfred Eugene Tucker, JR.						Month	Day	Year	8:08 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Male		Negro		May 21, 1935		33 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital		TRUCK DRIVER		Baltimore, Md.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Cockeysville				10804 Powers Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
ALFRED E. TUCKER, SR.						HELEN SMITH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of serv.)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
YES			213-30-2454		HELEN TUCKER-POWERS AVE COCKEYSVILLE MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute renal failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>2509</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
22a. I certify that (this hospital) attended the deceased from 12/18/1968, to 12/31/1968, that (we) last saw the deceased alive on 12/31/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Ramon P. Lopez, M.D.					12/31/68				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Ramon P. Lopez, M.D.					7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/6/69		Baltimore National		Baltimore, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. C. Chetani - 1701 M <sup>c</sup> Culloist		JAN 3 1969		J. Charles Judge					



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Nellie Leona TUCKER</b>			2a. DATE OF DEATH Month Day Year <b>Dec. 19 1968</b>		2b. HOUR M <b>8:15 P</b>
3. SEX <b>female</b>	4. RACE <b>white</b>		5. DATE OF BIRTH <b>Nov. 23, 1889</b>		6. AGE (In years last birthday) <b>79</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Balto.</b>		Md.			
10. CITY OR TOWN OF DEATH <b>Cockeysville</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Masonic Home of Md.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>—</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	
13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>1400 Marshall St.</b>			
14. FATHER'S NAME First Middle Last <b>Robert M. Marsh</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Jackson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-10-5339</b>		17. INFORMANT <b>Mrs. Grace Bradman</b>	
16c. ADDRESS <b>165 Rivera Drive</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio-sclerotic Vas. Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4</b>					
19a. DATE OF OPERATION <b>4-1-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 2 d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY Hour A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>—</b>	
21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) <b>—</b>		21f. LOCATION Street or R.F.D. No City or Town County State <b>—</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1, 1968</b> to <b>Dec. 19, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 19, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <b>Carl F. Benson MD</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED <b>Dec. 19, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Carl F. Benson MD</b>		22e. ADDRESS <b>5111 York Rd Balto. Md 21212</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-23-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK</b>	
23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD</b>					
24. FUNERAL DIRECTOR <b>Wm Cook-Bracks Tension</b>		ADDRESS <b>105 York Rd Balto Md 21202</b>		25a. RECD BY REGISTRAR <b>DEC 23 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove tabular papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 10 Film 408 1/7/69 kk										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
John C. Tydings						December 19, 1968		2 p. M.		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Male		White		March 24, 1907		81 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Balto. Md.		USA				Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			212 Blenheim Road			Supt. Nat. Paving Co.				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		212 Blenheim Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Milton A. Tydings			Lula E. Cromwell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT				
x no			212-56-1279			Mrs. Mary E. Tydings - 212 Blenheim Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 myocardial infarction									10 min	
DUE TO, OR AS A CONSEQUENCE OF (b)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 2-9-1942 to 12-19-1968, that (I) (we) last saw the deceased alive on 12-18-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death										
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Robert A. Reiter M.D.									12/19/68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Dr. Robert Reiter					606 Edmondson Ave. Catonsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
burial		12/23/68		Cedar Hill Cem		Balto. Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ADDRESS					DATE					
Mitchell-Wiedefeld Home 6500 York Rd. #21212					DEC 27 1968		Charles Judge			





17263

CERTIFICATE OF DEATH

17274

1 DECEASED-NAME (Type or print) <b>Kathleen S. Upduke</b>			2a DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>1968</b>			2b HOUR <b>7 P</b> M				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Aug. 1, 1901</b>		6 AGE (In years last birthday) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore Co. Md.</b>				
10 CITY OR TOWN OF DEATH <b>Cotuitville</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Summit Nursing Home</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a USLA. RES DENCE (Where deceased lived, if institution Res dence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Howard</b>		13c CITY OR TOWN <b>SALAZAR</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>202 Commercial St.</b>		
14 FATHER'S NAME First Middle Last <b>Samuel Stephen Spangler</b>			15. MOTHER'S MA DEN NAME First Middle Last <b>SALLY WAKEMAN</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or date of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>163x</b>		17. INFORMANT <b>Shelma Springer</b>				Address	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Progressive Cancer</b> <b>16 1</b> DUE TO, OR AS A CONSEQUENCE OF <b>Bone and Brain Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lung Cancer</b> (c) <b>Lung Cancer</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Mo</b> <b>4 Mo</b> <b>4 Mo</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>163x</b>										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that <b>4</b> (this hospital) attended the deceased from <b>Nov 7 1968</b> , to <b>Dec 23 1968</b> , that <b>1</b> (we) last saw the deceased alive on <b>12/23 1968</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(I)</b> (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Raymond D Bahr</b>				DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>12/23/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>RAYMOND D BAHR</b>				22e. ADDRESS <b>54 Acres Harp.</b>						
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>12-26-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem Park</b>		23d LOCATION (City or Town) (County) (State) <b>Md</b>				
24. FUNERAL DIRECTOR <b>Funeral Home of Dr. J. S. Jones</b>				ADDRESS <b>Dr. J. S. Jones</b>		25a REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>George O. Varner</b>						2a. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>68</b>			2b. HOUR <b>6.55 PM</b>		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>11-2-04</b>		6 AGE (In years last birthday) <b>64</b> YRS		7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8 UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md					
10 CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CLERICAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Essex</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>909 Barron Ave.- 21221</b>			
14 FATHER'S NAME First <b>GEORGE</b> Middle <b>O</b> Last <b>VARNER SR</b>						15 MOTHER'S MAIDEN NAME First <b>MARTHA</b> Middle <b>WEAVER</b> Last <b>WEAVER</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (g, or unknown) <b>NO</b>		16b SOCIAL SECURITY NO <b>214-09-3839</b>		17 INFORMANT <b>MAUDE VARNER</b>		Address <b>ABOVE</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Extensive Myocardial Infarction with Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>420.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>12-14-</b> , 19 <b>68</b> , to <b>12-19-</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-19-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Lilia C. Baldonado</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-19-68</b>					
22d PHYSICIAN'S NAME (Type) <b>Lilia C. Baldonado</b>		M.D.		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>12/27/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>GRAVES OF FAITH</b>		23d LOCATION (City or Town) <b>BALTO. MD</b>		(County) (State)			
24 FUNERAL DIRECTOR <b>J.G. CORNELLE SONS</b>		ADDRESS <b>300 MACE</b>		25a REC'D BY REGISTRAR <b>DEC 24 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



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VA R15  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Edith			Middle M.			Last Vizzini			2a. DATE OF DEATH Month Day Year December 29 1968			2b. HOUR M		
3 SEX F			4 RACE W			5. DATE OF BIRTH 11-29-1900			6. AGE (In years last birthday) 68 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md.					
10. CITY OR TOWN OF DEATH Arbutus			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 4411 Leeds Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Arbutus			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 4411 Leeds Avenue 21229					
14 FATHER'S NAME First Edward			Middle A			Last Disney			15 MOTHER'S MAIDEN NAME First Mollie			Middle L. Cunningham			Last		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-24-4786			17 INFORMANT John M. Vizzini			Address 4411 Leeds Ave. Arbutus Md			21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Mitral valve disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>acute regurgitation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1572</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No			City or Town			County			State		
22a. I certify that (I) (this hospital) attended the deceased from <u>August 7, 1968</u> , to <u>December 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Eugenio E. Benitez</u>			22c. DATE SIGNED <u>12/30/68</u>			22d. PHYSICIAN'S NAME (Type) Eugenio E. Benitez			22e. ADDRESS 3350 Wilkens Avenue								
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial			23b. DATE 1-2-1969			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) Ritchie Hwy, Baltimore Md.			(County) (State)					
24. FUNERAL DIRECTOR Howard H. Hubbard			ADDRESS 4107 Wilkens Ave. 21229			25a. REC'D BY REGISTRAR JAN 6 1969			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Laura V. Vojik</i>				2a. DATE OF DEATH Month <i>Dec</i> Day <i>20</i> Year <i>1968</i>				2b. HOUR <i>3 p M</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>October 1, 1888</i>		6 AGE (In years lost birthday) <i>80</i> YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md.					
10 CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holly Hill Conv. H me</i>		12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Rosedale</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1205 Hilldale Avenue</i>			
14. FATHER'S NAME First <i>James</i> Middle <i>Murphy</i> Last				15. MOTHER'S MAIDEN NAME First <i>Ann</i> Middle <i>Zeiller</i> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>213 28 7603D</i>		17. INFORMANT Address <i>Albert Kadlec 1205 Hilldale Road</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>June 4, 1968</i> , to <i>Dec. 20, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec. 20, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Laurence C. Post M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>12/21/68</i>							
22d. PHYSICIAN'S NAME (Type) <i>LAURENCE C. POST M.D.</i>				22e. ADDRESS <i>6805 York Rd - Baltimore Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Dec 23, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bohemian National Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>					
24. FUNERAL DIRECTOR <i>Regis Chas</i>		ADDRESS <i>1211 Chesaco Avenue</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR		
Bertha T. Waidner						December 31, 1968		10 A M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		
Female		White		Feb. 28, 1882		86 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
N. J.		U.S.A.				Baltimore				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Towson			Towson Convalescent Home			Housewife				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Baltimore				YES <input type="checkbox"/> NO <input type="checkbox"/>		225 Dumbarton Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
James H. Truitt			Rebecca Mattson							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
No					J. Truitt Waidner 225 Dumbarton Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 4-1-1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State		
22a I certify that (I) (this hospital) attended the deceased from July 10, 1968, to Dec 31, 1968, that (I) (we) last saw the deceased alive on Dec 31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Laurence C. Post M.D.</u>					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/31/68			
22d. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post					22e. ADDRESS 6805 York Rd. Baltimore, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		1-2-69		Loudon Park Cem.		Baltimore, Md.				
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
John F. Denny, Inc. 715 Light St. 21230					JAN 2 1969		Charles Judge			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		20. DATE OF DEATH		
CHARLES			THOMAS		WALLACE				Month	Day	
									12	10	
									Year	5:00P M	
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE			NEGRO		3/4/09		59 YRS		MONTHS		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		IF UNDER 24 HRS		
Baltimore, Md.			U.S.A.				BALTIMORE COUNTY		HOURS		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of year, or even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
FORT HOWARD			VET. ADM. HOSP. FT HOWARD, MD.		MECHANIC		AUTOMOBILE				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIMTS?		13e STREET AND NUMBER		
MARYLAND					BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		27 S. MONASTERY AVENUE		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First			Middle		Last		First		Middle		
CHARLES			WALLACE				BEATRICE		THOMAS		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)			16b SOCIAL SECURITY NO		17 INFORMANT		Address				
YES			WW II		219 03 13 26		CLIN. RECORDS, VA HOSP. FT HOWARD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLISM											
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE											
DUE TO, OR AS A CONSEQUENCE OF (c) RHEUMATIC HEART DISEASE											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
BRONCHOPNEUMONIA											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			NO AUTOPSY		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION			Street or R.F.D. No City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from 12/6/68, 19__, to 12/10/68 19__, that (I) (we) last saw the deceased alive on 12/10/68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						22c DATE SIGNED					
Man Arni Orer M.D.						12/11/68					
22d PHYSICIAN'S NAME (Type)						22e ADDRESS					
INFAN A. ORER, M. D.						VAH FORT HOWARD, MARYLAND					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
BURIAL			12/16/68		BALTO, NORT. CEM.			5501 FRESH K AVE.			
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
ELLIOTT FUNERAL HOME						DEC 13 1968			Charles Judge		
1129 Caroline St. Baltimore, Md.											



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <b>MAE</b>			First <b>MAE</b>			Middle <b>D.</b>			Last <b>WALPOLE</b>		
2a. DATE OF DEATH December 21 Day 1968						2b. HOUR 5:50 PM					
3 SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>4-14-04</b>			6 AGE (In years last birthday) <b>64</b> YRS		
7a BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore Md</b>		
10. CITY OR TOWN OF DEATH <b>Towson Baltimore</b>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>St. Joseph Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Arundel Ice Cream Co.</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Baltimore</b>			13c CITY OR TOWN <b>Dundalk</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME <b>Richard Conway</b>			First <b>Richard</b>			Middle <b>Conway</b>			Last <b>Christ</b>		
15 MOTHER'S MAIDEN NAME <b>Lillian</b>			First <b>Lillian</b>			Middle <b>Christ</b>			Last <b>Christ</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b SOCIAL SECURITY NO <b>214-22-9361</b>			17 INFORMANT (Son) <b>Mr. Mark G. Walpole, 1734 Wadsworth Way</b>			Address <b>Balto. Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable cirrhosis of the liver</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Probable cirrhosis of the liver</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			22b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			22c. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <b>12-3</b> , 19 <b>68</b> , to <b>12-21</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Camilo Z. Tomboc</b>						22c. DATE SIGNED <b>12-21-68</b>			22d. PHYSICIAN'S NAME (Type) <b>Camilo Z. Tomboc, M.D.</b>		
22e. ADDRESS <b>7620 York Rd. Towson, Maryland 21204</b>											
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>12/24/68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24 FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>						25a REC'D BY REGISTRAR <b>DEC 26 1968</b>			25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Lula M. Warner						12 Month 24 Day 68 Year			M
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		F. UNDER 1 YEAR MONTHS DAYS	
Female	Cauc.		December 29, 1884			83 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Baltimore Maryland			Shady Nook Nursing Home			housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Baltimore			1646 Forest Park Ave.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
(late) Adam Yingling			(late) Almota						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> NO			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
					Mrs. Shirley Mattingly 1646 Forest Park Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR HEMORRHAGE</u>								2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u>								15 years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
3:00									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 10-15, 1960, to 12-24, 1968, that (I) (we) lost the deceased alive on 12-23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Herman R. Kleiman		12/24/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
HERMAN R. KLEIMAN		3803 EDMONDSON AVE - 21229 -							
23a. BURIAL, CREMATION, REMOVA. (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/27/1968		Manchester Cemetery		Manchester Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. DECEASED BY REG. STATE		25b. DECEASED BY REG. STATE			
Witzke & Sons		4101 Edmondson Ave. Balto. Md.		DEC 27 1968					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
172821											
17282											
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
CARL			F. WASKIEWICZ			12/10/68			2:20A		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7c UNDER 1 YEAR		7d UNDER 24 HRS	
MALE		WHITE		10/22/15		53 YRS.		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARR.ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
MARYLAND			U.S.A.						BALTIMORE COUNTY, Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of previous life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VET. ARI. HOSP. FT HOWARD, MD.			SALESMAN			AUTO ACCESSORIES		
13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY, LIM. IS?		13e STREET AND NUMBER	
MARYLAND			CITY			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2110 PORTUGAL STREET	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
STEPHEN			WASKIEWICZ			SABINA			CZUPULSKI		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
YES			WW II			217 07 05 25			CLIN. RECORDS, VA HOSP. FT HOWARD, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GASTROINTESTINAL BLEEDING</u>											
571.9 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) <u>HEPATIC FAILURE</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>CIRRHOSIS OF LIVER</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
571											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			no autopsy		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory) Office, building, etc.			21f LOCATION Street or RFD No City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from 12/4/68, 19__, to 12/10/68, 19__, that (b) (we) last saw the deceased alive on 12/10/68, 19__, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.											
22b SIGNATURE						DEGREE			22c DATE SIGNED		
Man Arm Over M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			12/10/68		
22d PHYSICIAN'S NAME (Type)						22e ADDRESS					
INFAN A. ORER, M. D.						VAH FORT HOWARD, MARYLAND					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
BURIAL			12-13-68		Woodlawn of Mary			Baltimore County, Md.			
24 FUNERAL DIRECTOR											
2007 EASTERN Ave. FIALKOWSKI FUNERAL HOME											
25a REC'D BY REGISTRAR											
25b REGISTRAR'S SIGNATURE											
DEC 12 1968 J. Charles Judge											

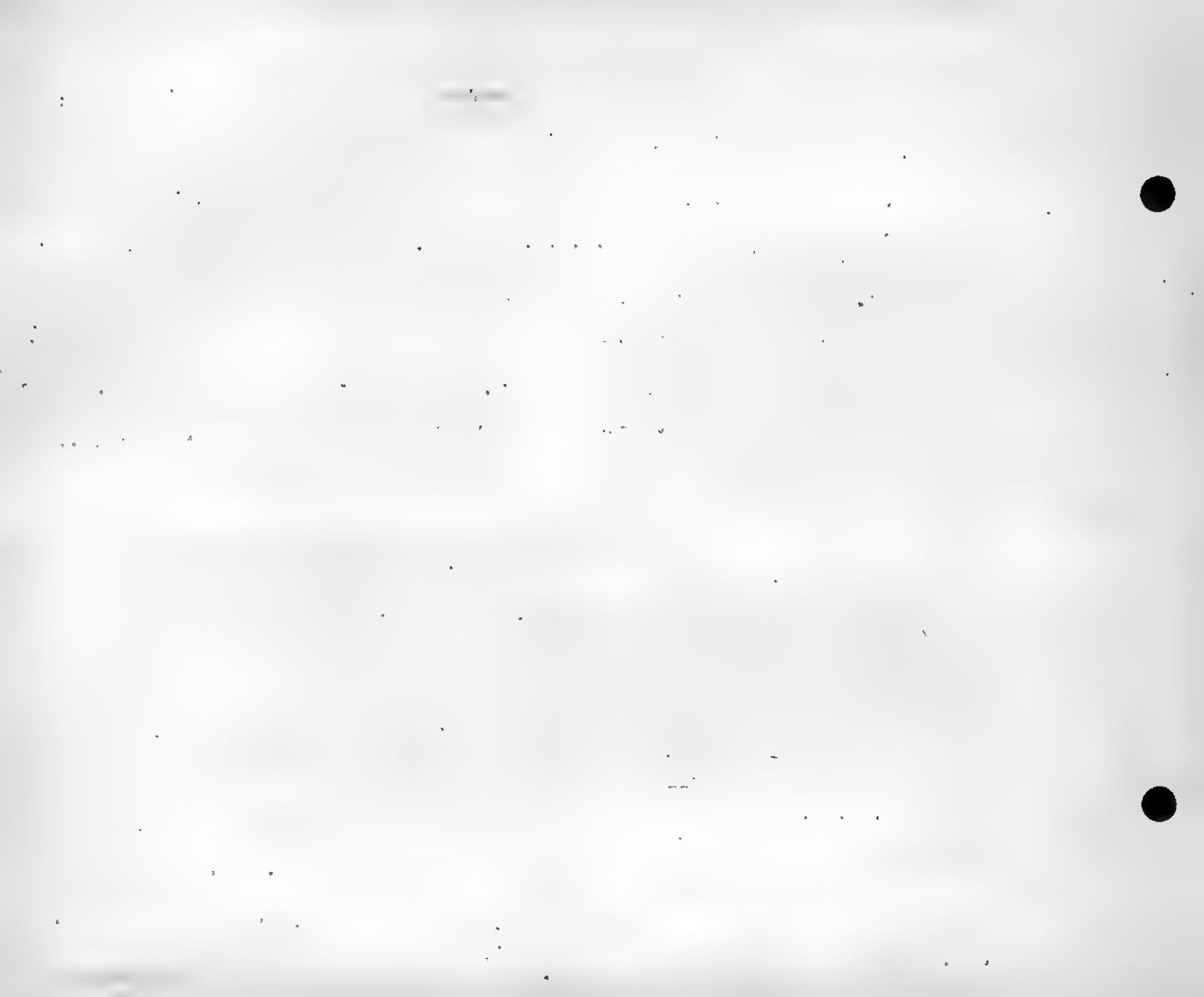
145-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First <b>LOUISE</b>			Middle <b>Pearce</b>			Last <b>WATTERS</b>			2a. DATE OF DEATH <b>12</b> Month <b>28</b> Day <b>68</b> Year			2b. HOUR <b>7:20 P M</b>		
3 SEX <b>FEMALE</b>			4 RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH <b>3/25/1893</b>			6. AGE (in years last birthday) <b>75</b> YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>BALTIMORE COUNTY</b> Md.								
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>G.B.M.C.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Monkton</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>Manor Road</b>					
14. FATHER'S NAME First Middle Last <b>Harry T. Pearce</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Hutkins</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO <b>216-46-6030</b>			17 INFORMANT Address <b>Mrs. Douglas R. Small, Manor Rd. Monkton Md.</b>											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>2320</b> DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>5410</b> ) (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>SEVERE, PROFUSE BLEEDING FROM G I TRACK, WITH SHOCK</b>																	
19a. DATE OF OPERATION <b>12/25 &amp; 26</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>1) Bleeding from a duodenal ulcer 2) continuous bleed- ing multiple sites</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>December 25, 1968</b> , to <b>December 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>December 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Dr. J. C. Aguilar</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12/28/68</b>								
22d. PHYSICIAN'S NAME (Type) <b>Dr. J. C. Aguilar</b>			22e. ADDRESS <b>Greater Balto. Med. Center</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/31/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>								
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>			ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>			25a. REC'D BY REGISTRAR <b>DATE JAN 2 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17283

CERTIFICATE OF DEATH

17284

1. DECEASED-NAME (Type or print) <b>JOHN FRANKLIN WEAVER</b>			2a. DATE OF DEATH <b>12</b> Month <b>18</b> Day <b>68</b> Year		2b. HOUR <b>7:40 P.M.</b>
3 SEX <b>M.</b>	4 RACE <b>W</b>	5. DATE OF BIRTH <b>8/29/1888</b>		6. AGE (in years last birthday) <b>80</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Armstrong Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>retired Presbyterian Clergyman</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>8005 York Road</b>
14. FATHER'S NAME First Middle Last <b>George W. Weaver</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Henrietta Fulton</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>213-05 9740</b>		17. INFORMANT Address <b>Mrs. Bess Weaver Gray 804 Fairway Dr. #21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITUS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>4 yrs</b> <b>4 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>ARTERIOSECTOMY CARDIOVASCULAR DISEASE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 1, 1960</b> , to <b>DEC 18, 1968</b> , that (I) (we) last saw the deceased alive on <b>December 18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>S. J. VENABLE, JR. M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12-18-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>S. J. VENABLE, JR. M.D.</b>		22e. ADDRESS <b>7215 YORK RD BALTIMORE M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>12/22/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Muddy Creek</b>		23d. LOCATION (City or Town) (County) (State) <b>Greene County, Penna.</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home 6500 York Rd. Balto. Md. 21212</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

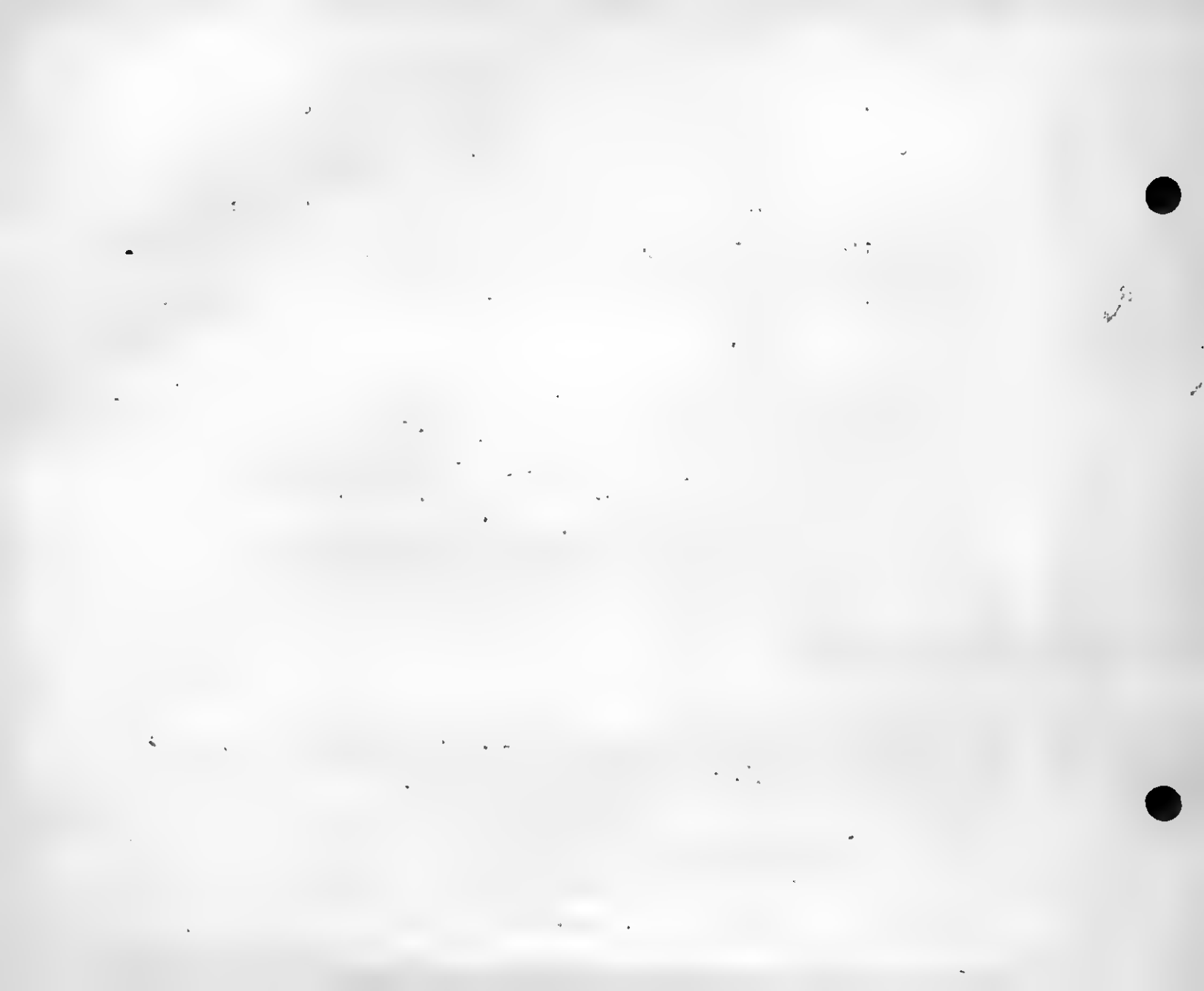


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) DR. ELMORE			First Middle Last M.			2a. DATE OF DEATH Month Day Year December 20 1968			2b. HOUR M
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Aug. 16, 1899			6. AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10611 York Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dentist			12b. KIND OF BUSINESS OR INDUSTRY Dental	
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 10611 York Rd.	
14. FATHER'S NAME First Middle Last Samuel Martin Webb			15. MOTHER'S MAIDEN NAME First Middle Last Mary Frances Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 213-38-6177.		17. INFORMANT Address Mrs. Clarice J. Webb Same as # 13 E			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chr. Tracheal Obstruction</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>2 yrs.</u> <u>5 yrs.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-18-1965</u> to <u>12-20-1968</u> , that (I) (we) last saw the deceased alive on <u>12-18-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>12:03 PM</u>									
22b. SIGNATURE <u>[Signature]</u> M.D.				ATTENDING PHYS. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12-21-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>W.H. River</u>				22e. ADDRESS <u>31059 Charles St.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-23-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Methodist			23d. LOCATION (City or Town) (County) (State) Mt. Carmel Rd. Maryland		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.				ADDRESS 1050 York Rd.		25a. REC'D BY REGISTRAR DEC 24 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) <b>Frederick</b>		First <b>G</b>		Middle <b>Heber</b>		Last		2a. DATE OF DEATH Month <b>12</b> Day <b>12</b> Year <b>68</b>		2b HO JR <b>230 M</b>
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>Dec .5 1877</b>		6. AGE (in years lost birthday) <b>91</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Germany</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		12b KIND OF BUSINESS OR INDUSTRY		12c
10 CITY OR TOWN OF DEATH <b>Garrison</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Maxleigh Nursing</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		13a INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13b STREET AND NUMBER <b>601 East 37th St</b>		13c
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e STREET AND NUMBER <b>601 East 37th St</b>		13f
14 FATHER'S NAME <b>Frederick</b>		First <b>Weber</b>		Middle		Last		15 MOTHER'S MAIDEN NAME First <b>Wilhemina</b>		Middle <b>Faulbusch</b>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown) <b>No.</b>		(If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>217-07-8810 A</b>		17 INFORMANT <b>Mrs Laura G Myrick</b>		Address <b>5310 A Leith Rd</b>		17b
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>4:30</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>years</b>
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		20c		20d
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f
21f LOCATION Street or R.F.D. No		City or Town		County		State		21g		21h
22a I certify that (I) (this hospital) attended the deceased from <b>10-1</b> , 19 <b>68</b> , to <b>12-12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>David J. Miller MD</b>		22c DATE SIGNED <b>12-12-68</b>		22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f		22g
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>12/12/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		23e		23f
24 FUNERAL DIRECTOR <b>L. J. Ruck Inc.</b>		ADDRESS <b>BALTO. MD.</b>		25a REC'D BY REGISTRAR <b>DEC 13 1968</b>		25b REGISTRAR'S SIGNATURE <b>John J. Judge</b>		25c		25d



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

172876

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17287

1. DECEASED-NAME (Type or print) <b>John Leonard Weber</b>			20. DATE OF DEATH 12 Month 27 Day 1968			2b. HOUR <b>P</b> 2:40M					
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>March 5, 1886</b>		6. AGE (In years lost birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore Md</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dulaney Towson Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during last year, even if retired) <b>accountant</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if not in institution, residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>231 Rogers Forge Road, 21212</b>	
14. FATHER'S NAME <b>J. Leonard Weber</b>			15. MOTHER'S MAIDEN NAME <b>Elise</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)					
16a. SOCIAL SECURITY NO. <b>215-07-1376</b>			17. INFORMANT <b>Dulaney Towson Nursing Home, 111 West Road,</b>			Address <b>21204</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> <b>40.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4500</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>June 6, 1964</b> to <b>12/27, 1968</b> , that (I) (we) last saw the deceased alive on <b>12/27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>Laurence C. Post</b>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>12/30/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. Laurence C. Post</b>					22e. ADDRESS <b>6805 York Rd. Baltimore, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd.</b>					25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



**FOR STATE  
HEALTH DEPT.**

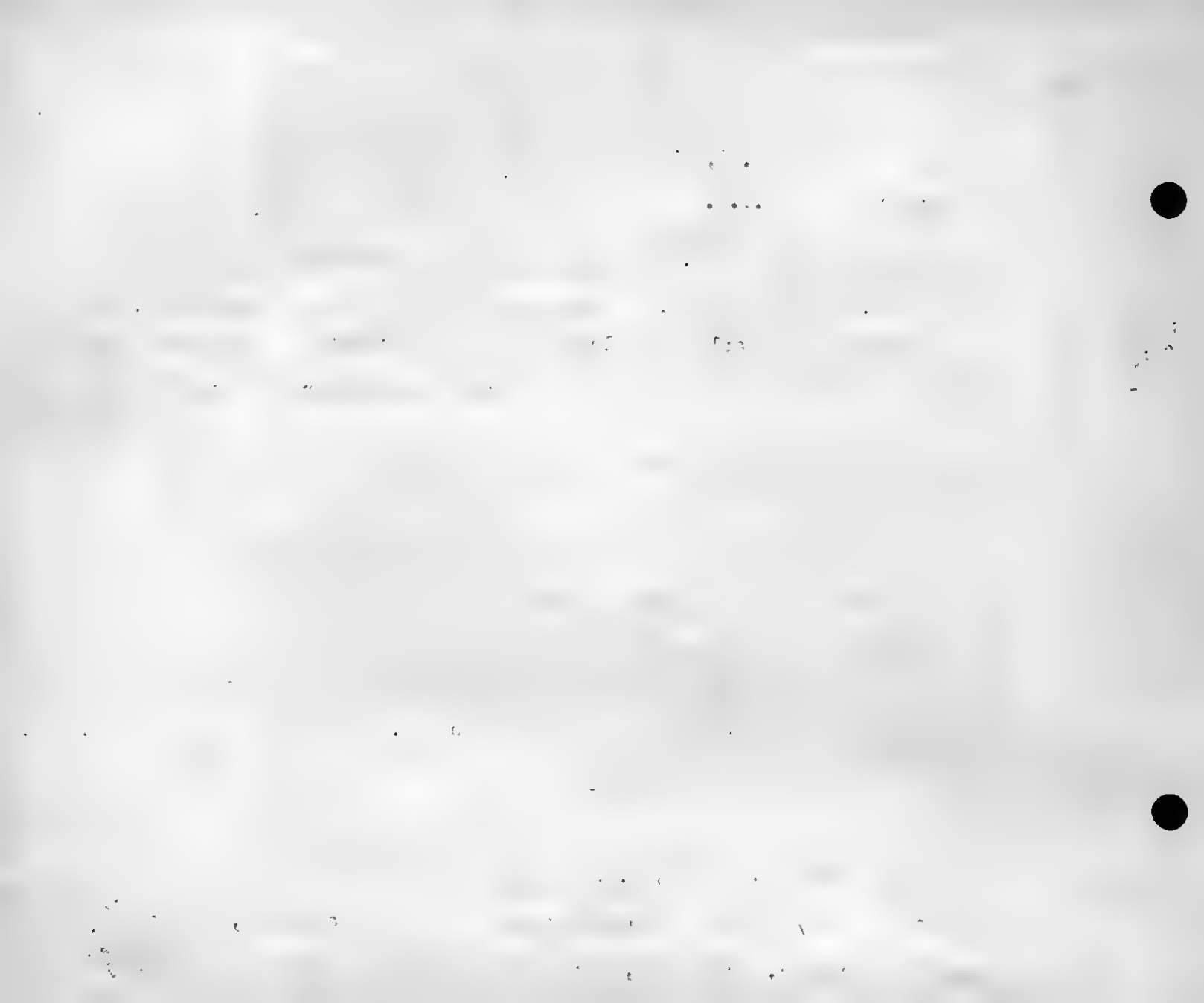
**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17288

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
PATRICIA ANN WEINBERGER						12 17 19			687:35p						
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	7. UNDER 1 YEAR		8. UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR				
Female	White	Aug. 17, 1932	36 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year							
7a. BIRTH-PLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Maryland			U.S.A.						Balto.			Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Towson			St. Joseph Hospital			Secretary									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
Md.			Balto.			Timonium			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			220 Cinder Rd.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Alfred Carl Miller			Frances Madeline Hardy												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No						Mr Carl J Weinberger			9404 Avondale Rd						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Injuries</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) <u>8121</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
<u>1164</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
				HOUR <u>6:55 PM</u> 12 17 68				Subject passenger in auto-auto collision							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
				St.				PotSpring Rd. Timonium Balto. Md.							
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
<u>Edward F. Wilson</u>				ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				12/18/68							
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)							
Edward F. Wilson, M.D.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				12/21/68m				Dulaney Valley				Baltimore, Maryland			
24. FUNERAL DIRECTOR				ADDRESS				25. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc.				Baltimore, Maryland				DEC 19 1968				<u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

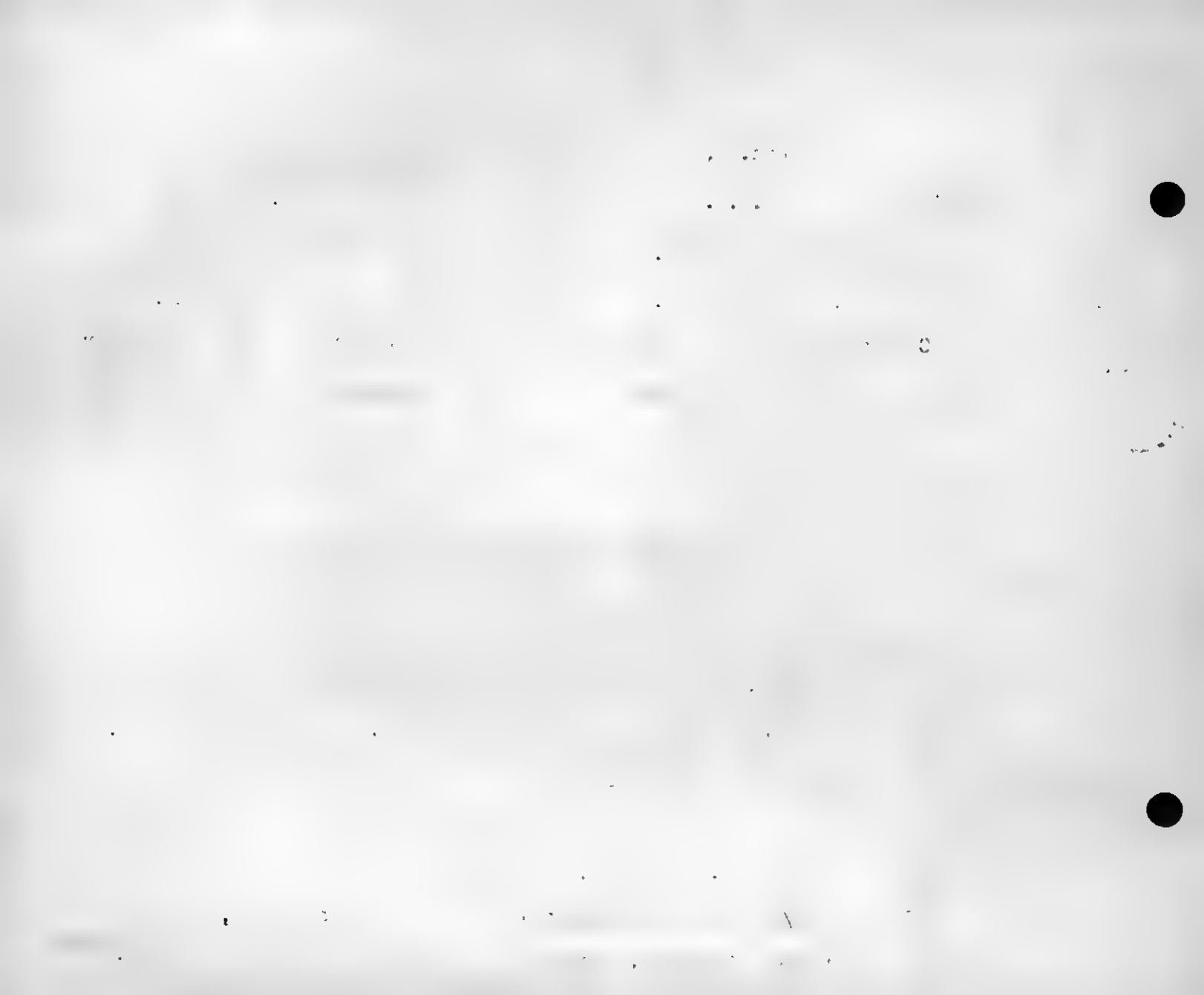
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17278

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17289

1. DECEASED-NAME (Type or Print)			First <b>SCOTT</b>			Middle <b>ALLAN</b>			Last <b>WEINBERGER</b>			2c. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>			2b. HOUR <b>7:25p</b>								
3 SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Jan. 31, 1962</b>			6. AGE (In years last birthday) <b>6 YRS</b>			IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>			F UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>			2d. HOUR <b>7:25p</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Balto.</b>						Md								
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Student</b>			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Timonium</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>220 Cinder Rd.</b>											
14. FATHER'S NAME First <b>Carl</b> Middle <b>S</b> Last <b>Weinberger</b>			15. MOTHER'S MAIDEN NAME First <b>Patricia</b> Middle <b>Ann</b> Last <b>Miller</b>																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mr Carl J Weinberger</b>						ADDRESS <b>9404 Avondale Rd</b>											
17b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cranio-cerebral injuries</b>																							
8121 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost																							
(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b>																							
(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION <b>12/17/68</b>																		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>6:55 PM 12 17 19 68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Subject passenger in auto-auto collision</b>																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>St.</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>Potspring Rd. Timonium Balto. Md.</b>																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b>			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MED CAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>12/18/68</b>								
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/21/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>														
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc</b>			ADDRESS <b>Baltimore, Maryland</b>			25a. REC'D BY REGISTRAR <b>DEC 19 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>														





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print)			First <b>Edith</b>			Middle <b>V.</b>			Last <b>Wernig</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>1968</b>			2b. HOUR <b>M</b>	
3. SEX <b>F</b>			4. RACE <b>W</b>			5. DATE OF BIRTH <b>10-29-1902</b>			6. AGE (In years last birthday) <b>66</b> YRS			IF UNDER 1 YEAR MONTHS <b>66</b>		IF UNDER 24 HRS. DAYS <b>66</b>		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>736 Warwick Road 21229</b>			12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired.) <b>Interior Decorator</b>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>736 Warwick Road 21229</b>				
14. FATHER'S NAME First <b>Eugene</b> Middle <b>Greenstreet</b> Last <b>Eugene Greenstreet</b>						15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Slaughter</b> Last <b>Margaret Slaughter</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO <b>220-07-1485</b>			17. INFORMANT Address <b>Joseph S. Wernig, Jr. 736 Warwick Rd. 21229</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>1971</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1. _____</b>																
19a. DATE OF OPERATION <b>10/30/1968</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>diagnosis noted</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>car</b>										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE-BUILDING, ETC.) <b>car</b>			21f. LOCATION Street or R.F.D. no _____ City or Town _____ County _____ State _____										
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 3, 68</b> to <b>Dec 6, 68</b> , that (I) (we) last saw the deceased alive on <b>Dec 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																
22b. SIGNATURE <b>Earl I. Pass</b>						22c. DATE SIGNED <b>12-6 68</b>			22d. PHYSICIAN'S NAME (Type) <b>Earl I. Pass</b>							
22e. ADDRESS <b>4001 Wilkens Avenue, Balto 21229</b>																
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>			23b. DATE <b>12-9-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Mansoleum</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore City, Balto Md.</b>							
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17290		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17291	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
JAMES		M		WERTZ Sr	December 5, 1968		5:00 P.M.
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
male		caucasian		Feb. 14, 1896		72 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
New Freedom, Pa.		USA				Baltimore Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore 34 (rural)		9108 Covered Bridge Rd.		Streetcar Motorman		BTC	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.		Balto.		rural Balto		9108 Covered Bridge Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Thomas Wertz		Agnes Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
No		215-09-3863		Mrs. Mamie W. Wertz		(Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>						Time in life	
4109 DUE TO, OR AS A CONSEQUENCE OF						2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Coronary Heart Disease</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
7 x 11							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1966</u> , to <u>Dec 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS			
Dr. Loy M. Zimmerman		3202 Harford Rd, Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
burial		12-9-68		Dulaney Valley Cemetery		Dulaney Valley, Md.	
24. FUNERAL DIRECTOR		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc....Baltimore, Md.		DATE DEC 9 1968		Phonetic Judge			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
17281		17292	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>		c. LENGTH OF STAY IN 1b <b>Life-time</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		d. STREET ADDRESS <b>19 Walker Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>19 Walker Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Pearl Bowersox Whaley</b>		4. DATE OF DEATH <b>Dec. 23, 1968</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1885</b>
9. AGE (in years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wm. J. Foley, Co.</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Pikesville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Bowersox</b>		14. MOTHER'S MAIDEN NAME <b>Fannie R. Myerly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO <b>212-05-7626A</b>	
17. INFORMANT <b>Mr. Edward Bowersox</b>		Address <b>Pikesville</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 4109 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4201</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>9-30, 1968</b> to <b>12-23, 1968</b> , that (I) (we) last saw the deceased alive on <b>12-13, 1968</b> , and that death occurred at <b>8:00 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Samuel V. Scalia</b> M.D.		22b. DATE SIGNED <b>12-24-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel V. Scalia</b>		22d. ADDRESS <b>2 Shawwood Ave Pikesville</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 26, 1968</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Frank H. Newell</b>		25a. REC'D BY REGISTRAR <b>DEC 26 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 1 Film 408 12/31/68 kk					CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <b>Joseph John</b>			First Middle Last <b>A. Wieber</b>			2a. DATE OF DEATH Month Day Year <b>December 24 1968</b>			2b. HOUR M	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>1-14-1892</b>		6. AGE (In years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Howard Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Shangri-La Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USJAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>24 Durham Road 21043</b>	
14. FATHER'S NAME First Middle Last <b>Joseph Wieber</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Henrietta Denges</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-05-3010</b>		17. INFORMANT <b>West Ellicott City Address 21043</b> <b>Estella Biemiller 24 Durham Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>41x4 CARDIAC ARREST.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>10 D.</b> (b) <b>LOBAR PNEUMONIA / BRONCHITIS -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> <b>10 YR.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CIRCULATORY INSUFFICIENCY.</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>10-29, 1967</b> , to <b>12-24, 1968</b> , that (I) (we) last saw the deceased alive on <b>12-23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>P. Thorpe</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>Peter Van B. Thorpe</b>					22e. ADDRESS <b>21 S. St. Johns Lane</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-28-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore City Balto., Md.</b>			
24. FUNERAL DIRECTOR <b>Howard H. Hubbard 4107 Wilkens Ave. Balto 29</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
45M 1/69

<div style="display: flex; justify-content: space-between;"> <span>17283</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>17294</span> </div>													
1 DECEASED NAME (Type or print)			First <b>LESTER</b>		Middle <b>- -</b>		Last <b>WILDER</b>		2a. DATE OF DEATH Month <b>7</b> , Day <b>1968</b> Year			2b. HOUR <b>2:30p M</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>1/9/12</b>			6 AGE (In years last birthday) <b>56</b> YRS.		F. UNDER 1 YEAR MONTHS		F. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>TENNESSEE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <b>BALTIMORE</b> Md							
10 CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMIN. HOSPITAL</b>				12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) <b>STONE MASON</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>SYKESVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>GAITHER ROAD</b>					
14. FATHER'S NAME			First <b>JAMES</b>		Middle <b>- -</b>		Last <b>WILDER</b>		15. MOTHER'S M.A.DEN NAME			First <b>ALPHA</b> Middle <b>- -</b> Last <b>PERRY</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO <b>219 07 11 78</b>		17. INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>									
18. CAUSE OF DEATH (Enter on only one cause per line for (a) (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b>												DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>												YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 3</b> , 19 <b>68</b> , to <b>DEC 7</b> , 19 <b>68</b> , that <del>we</del> (we) last saw the deceased alive on <b>DEC 7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE 		DEGREE <b>MARIO J. QUIROS, M.D.</b>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/8/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>MARIO J. QUIROS, M.D.</b>		22e. ADDRESS <b>VAH, FT. HOWARD, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>UNION BAPTIST CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD. Lishen, Md</b>					
24. FUNERAL DIRECTOR <b>HAIGHT FUNERAL HOME, SYKESVILLE, MD.</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE 					

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year	
George		Chester		Wilhelm		December		7 68	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS	
Male		White		1-18-98		70 YRS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital		LABORER		BREWERY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS OF CITY, MTS?		13e. STREET AND NUMBER	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		611 S. Montford Ave.-21224	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
JOHN		WILHELM						ANNA WEISS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
YES		WWIT		214-03-2547		MRS STELLA WILHELM			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Lobar Pneumonia</u>									
197.8 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) <u>Metastatic carcinomatosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
15									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
12-5-68		Metastatic ca., liver.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town County State	
22a I certify that (A) (this hospital) attended the deceased from <u>11/16/</u> , 19 <u>68</u> to <u>12/7/</u> , 19 <u>68</u> , that (A) (we) last saw the deceased alive on <u>12/7/</u> , 19 <u>68</u> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Ines Cilliani, M.D.						December 8, 1968			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
		7620 York Rd., Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)			
BURIAL		12-11-1968		Holy Rosary Cemetery		BALTIMORE		MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
RAYMOND L. KACZOROWSKI		2525 FLEET ST.		DEC 20 1968		J Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

172855

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17286

1. DECEASED NAME (Type or print) <b>Gladys Sarah Wilhelm</b>			2a. DATE OF DEATH 12/31/68			2b. HOUR 4:10 a.m.			
3. SEX <b>Female</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH <b>4/1/12</b>		6. AGE (in years last birthday) <b>56</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Cockeysville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Shawan Road, Box 113</b>	
14. FATHER'S NAME <b>Harvey Henry</b>			15. MOTHER'S MAIDEN NAME <b>Hunt</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>212-24-8517</b>		17. INFORMANT <b>Family records</b>		Address			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease with</b> <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> , 19 <b>68</b> , to <b>12/31</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Charles C. Brown, M.D.</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/31/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Charles C. Brown, M.D.</b>				22e. ADDRESS <b>6701 N. Charles Street</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 3, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Falls Road Chapel Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Butler, Maryland</b>			
24. FUNERAL DIRECTOR <b>John Burns Sons Towson</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

172976										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17297			
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR			
First			Middle			Last				Month		Day		Year		HOURS		MIN.					
GORDON			DOUGLAS			WILLIAMS				DECEMBER		31		1968		7:15P		M					
3. SEX			4. RACE			5. DATE OF BIRTH				6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.									
MALE			CAUCASIAN			AUGUST 10, 1910				58		YRS		MONTHS		DAYS		HOURS					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH													
CONN.			U.S.A.							BALTIMORE													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY													
FORT HOWARD			HOSPITAL VETERANS ADMINISTRATION			INSURANCE AGENT																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?				13d. STREET AND NUMBER													
MARYLAND			BALDWIN			YES <input type="checkbox"/> NO <input type="checkbox"/>				BOX #313F													
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																				
First			Middle			Last			First			Middle			Last								
CHARLES			WILLIAMS			CATHERINE WALKER																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address																	
YES			WW II			472 05 1596			CLINICAL RECORDS VA HOSP, FT HOWARD, MD														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA																		4 DAYS					
DUE TO, OR AS A CONSEQUENCE OF (b) MALNUTRITION																		MONTHS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) CHRONIC ALCOHOLISM																		YEARS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																							
3221																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)																	
			HOUR A.M. Month Day Year P.M. 19																				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State																	
22a. I certify that (this hospital) attended the deceased from 12/27/68, 19__, to 12/31/68, 19__, that (we) last saw the deceased alive on 12/31/68, 19__, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.																							
22b. SIGNATURE Han Anni Orel M.D.																		22c. DATE SIGNED					
DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>																		12/31/68					
22d. PHYSICIAN'S NAME (Type) VA HOSPITAL, FORT HOWARD, MARYLAND																							
23a. BURIAL, CREMATION, OR OTHER DISPOSITION			23b. DATE			23c. NAME OF CEMETERY				23d. LOCATION (City or Town) (County) (State)													
BURIAL			Jan. 3, 1969			BALTO NATIONAL CEMETERY				BALTIMORE, MARYLAND													
24. FUNERAL DIRECTOR ADDRESS																		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
BURNS FUNERAL HOME, YORK RD, TOWSON, MD																		JAN 6 1969					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

17288										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17298									
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last <b>Robert Lee Williams</b>										Month Day Year <b>12 11 1968</b>										Hour <b>12 P M</b>									
3 SEX <b>Male</b>			4 RACE <b>White</b>			5 DATE OF BIRTH <b>8-21-1901</b>			6 AGE (in years last birthday) <b>67 YRS.</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>67 YRS.</b>			IF UNDER 24 HRS HOURS MIN <b>67 YRS.</b>														
7a BIRTHPLACE (State or foreign country) <b>North Carolina</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore,</b> Md																				
10 CITY OR TOWN OF DEATH <b>Towson</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life or if retired) <b>Procurement Officer</b>			12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>																				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Baltimore</b>			13c CITY OR TOWN <b>Baltimore</b>			13d INSIDE CITY (Y/N) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER <b>617 Piccadilly Rd.</b>																	
14 FATHER'S NAME First Middle Last <b>William E. Williams</b>					15 MOTHER'S M A DEN NAME First Middle Last <b>Rachel Eugenia Henry</b>					16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>No</b>										16b SOCIAL SECURITY NO <b>213-10-9025</b>					17 INFORMANT Address <b>Mrs. Bertie S. Williams 617 Piccadilly Rd 21204</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4/10/1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) _____ stating the underlying cause (c) _____ last (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>42</b>																													
19a DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that <b>10</b> (this hospital) attended the deceased from <b>12/10/</b> , 19 <b>68</b> , to <b>12/11/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/11/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.																													
22b SIGNATURE <b>Lorna Gaudiol, M.D.</b>										DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c DATE SIGNED <b>12/11/68</b>														
22d PHYSICIAN'S NAME (Type) <b>Lorna Gaudiol, M.D.</b>										22e ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>																			
23a BURIAL, CREMATION, REMOVAL <b>Burial</b>					23b DATE <b>12-14-1968</b>					23c NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>					23d LOCATION (City or Town) (County) (State) <b>Cockeysville, Maryland</b>														
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>										ADDRESS <b>1050 York Rd. 21204</b>					25a REC'D BY REGISTRAR <b>DEC 13 1968</b>					25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR			
STANLEY			WILLIAMS			Month Day Year		M			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	2c DATE PRONOUNCED DEAD		2d HOUR			
Male	Negro	Sept. 15, 1941	27 YRS			Month Day Year		4:05 A.M.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md.		U.S.A.				BALTIMORE		Md.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		2b KIND OF BUSINESS OR INDUSTRY			
(near) Timonium			Harrisburg Expressway			Laborer					
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS OF CITY LIMITS?		13e STREET AND NUMBER		
Md.					Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		1904 East Federal Street		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Henry Williams			Beatrice Goldchrist								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS				
no					Adrie Williams						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Blunt chest injuries											
8120 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			3:14 P.M. 12-15-1968		Driver in auto-auto collision						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State						
			Expressway		Harrisburg Express #1-18 1/4 mi. S. of Padonia Rd. Timonium Baltimore Md.						
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL EXAMINER'S SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED			
Charles S. Springate, M.D.								December 15, 1968			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial			12/17/68		Mt. Carey Cem		All County Md.				
24 FUNERAL DIRECTOR					ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Fred T. Elickson 1129 N. Caroline St.							DATE DEC 18 1968		Charles Judge		



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
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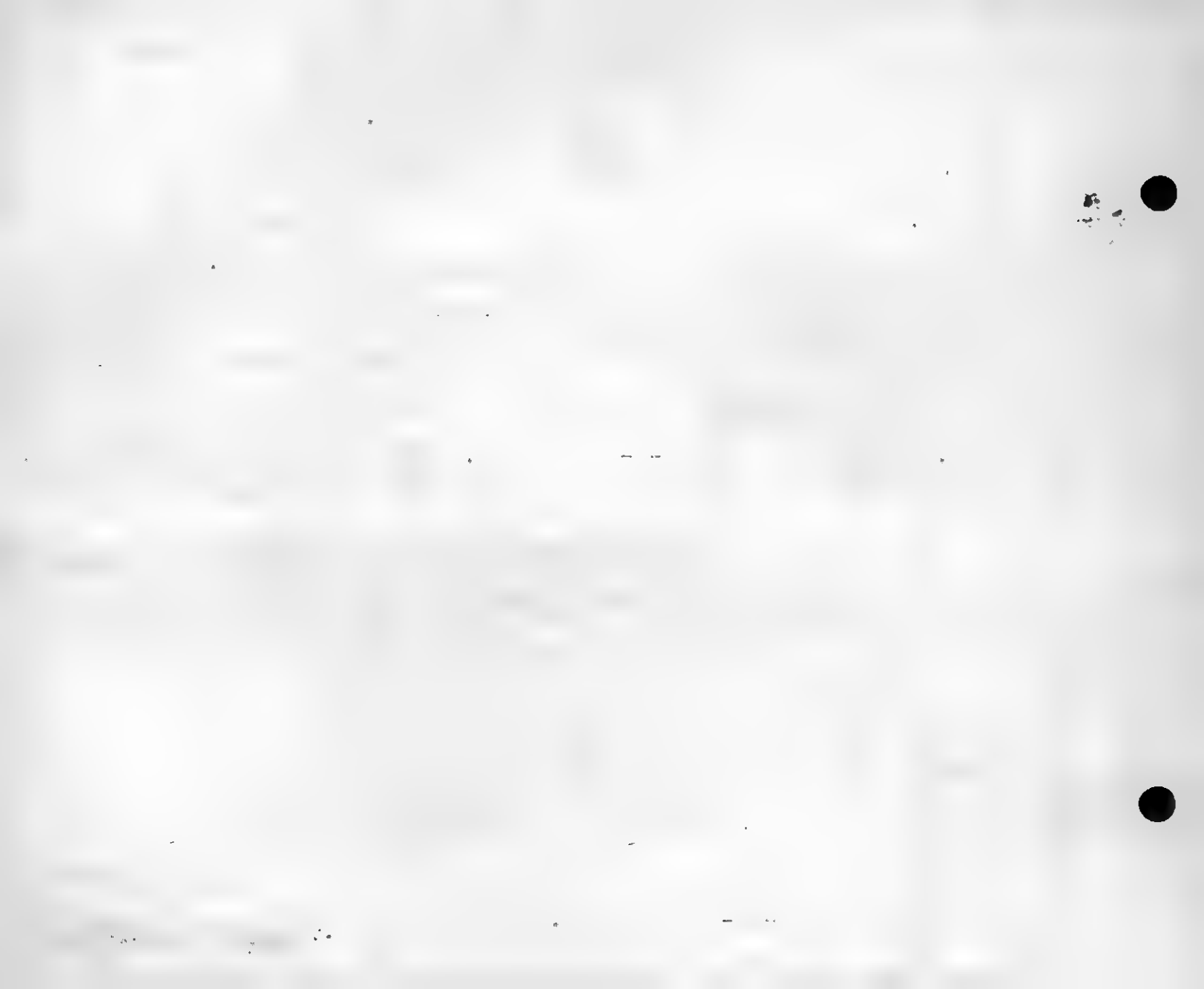
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17289

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17300

1 PLACE OF DEATH a. COUNTY <b>Towson</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Towson</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN lb <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH'S HOSPITAL</b>		e. STREET ADDRESS <b>373 Hillen Road</b>	
3 NAME OF DECEASED (Type or print) First <b>JOHNNIE</b> Middle <b>E.</b> Last <b>WILSON</b>		4 DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>1968</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-28-1968</b>
9 AGE (in years last birthday) <b>10</b> yrs		10 IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min <b>10</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>WILLIE HOUSTON</b>		14 MOTHER'S MAIDEN NAME <b>REGINA WILSON</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16 SOCIAL SECURITY NO. <b>-0-</b>	
17 INFORMANT <b>Mrs. Regina Wilson</b>		Address <b>373 Hillen RD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).) PART I DEATH WAS CAUSED BY <b>746.2</b> IMMEDIATE CAUSE (a) DUE TO (b) <b>Concurrent Heart Disease</b> DUE TO (c) <b>Technique of Fallot</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>7</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the removals described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		22 DATE SIGNED <b>12/24/68</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		23a BUREAU OF MEDICAL EXAMINER <b>ASSISTANT MEDICAL EXAMINER</b>	
23b BUREAU OF MEDICAL EXAMINER <b>DEPUTY MEDICAL EXAMINER</b>		23c ADDRESS (Street, city, town, or county)	
23d BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23e DATE THEREOF <b>12-30-68</b>	
23f NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l Cem.</b>		23g LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR <b>MORTON &amp; O'GETT F.H.</b>		25a RECEIVED BY REGISTRAR <b>LAURENS S. GREGG</b>	
25b RECEIVED BY REGISTRAR <b>DEC 27 1968</b>		25c DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 407 k2-23-68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
17200 CERTIFICATE OF DEATH 17301

1 DECEASED NAME (Type or print) First Middle Last <b>Sophia A. WISCH</b>			2a DATE OF DEATH Month Day Year <b>12 3 68</b>		2b HOUR <b>10:20</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>5/10/02</b>		6 AGE (In years lost birthday) <b>66</b> YRS.	7 UNDER 1 YEAR MONTHS DAYS <b>66</b>
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Naturalized U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH <b>Baltimore</b>		Md			
10. CITY OR TOWN OF DEATH <b>Owings Mills</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rosewood State Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Dependent</b>	
12b KIND OF BUSINESS OR INDUSTRY <b>none</b>					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Baltimore</b>	13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>1037 Rockhill Avenue</b>
14. FATHER'S NAME First Middle Last <b>Julius - Wisch</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Natalie - Simokot</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		16b. SOCIAL SECURITY NO <b>213-58-4202T</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Primary site unknown</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from <b>11/24</b> , 19 <b>58</b> , to <b>12/3</b> , 19 <b>68</b> , that (X) (we) lost saw the deceased alive on <b>12/3</b> , 19 <b>68</b> , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (view) view the body after death.					
22b SIGNATURE <b>Nevzat Turkman, M.D.</b>				22c. DATE SIGNED <b>12/4/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Nevzat Turkman, M.D.</b>				22e. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western</b>	
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave., 21229</b>		25a. REC'D BY REGISTRAR <b>DEC 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17291										17302									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>GEORGE W</b>					First Middle Last					2a. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>68</b>					2b. HOUR <b>1105PM</b>				
3 SEX <b>Male</b>			4 RACE <b>White</b>			5 DATE OF BIRTH <b>Nov. 6, 1895</b>			6 AGE (In years last birthday) <b>73</b> YRS			7 FUNDER 1 YEAR MONTHS <b>73</b> DAYS <b>73</b>			8 UNDER 24 HRS HOURS <b>73</b> MIN <b>73</b>				
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.										
10 CITY OR TOWN OF DEATH <b>Catonsville</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address) <b>Summit Nursing Home</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Engineer State Roads Com.</b>			12b KIND OF BUSINESS OR INDUSTRY										
13a U.S.A. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Landsdowne</b>			13c CITY OR TOWN <b>Landsdowne</b>			13d INSIDE CITY LIM TST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER <b>2409 Brunswick Rd</b>							
14 FATHER'S NAME First <b>Charles</b> Middle <b>M</b> Last <b>Wolf</b>					15 MOTHER'S MAIDEN NAME First <b>Frederica</b> Middle <b>?</b> Last <b>?</b>														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)					16b SOCIAL SECURITY NO <b>214-22-5849</b>					17. INFORMANT Address <b>Same</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the prostate with</b>																			
DUE TO, OR AS A CONSEQUENCE OF <b>Widespread metastases</b>																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital), attended the deceased from <b>2/16</b> , 19 <b>68</b> , to <b>12/19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/18</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b SIGNATURE <b>E. KASARITS, M.D.</b>										DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c DATE SIGNED <b>12/19/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>E. KASARITS, M.D.</b>										22e ADDRESS <b>1801 FREDERICK ROAD BALTO 28</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>12/23/68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>					23d. LOCAT ON (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24 FUNERAL DIRECTOR <b>Leonard J Ruck Inc Baltimore, Maryland</b>										25a. REC'D BY REGISTRAR <b>DEC 23 1968</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PMS Page 5 may be retained for your files.

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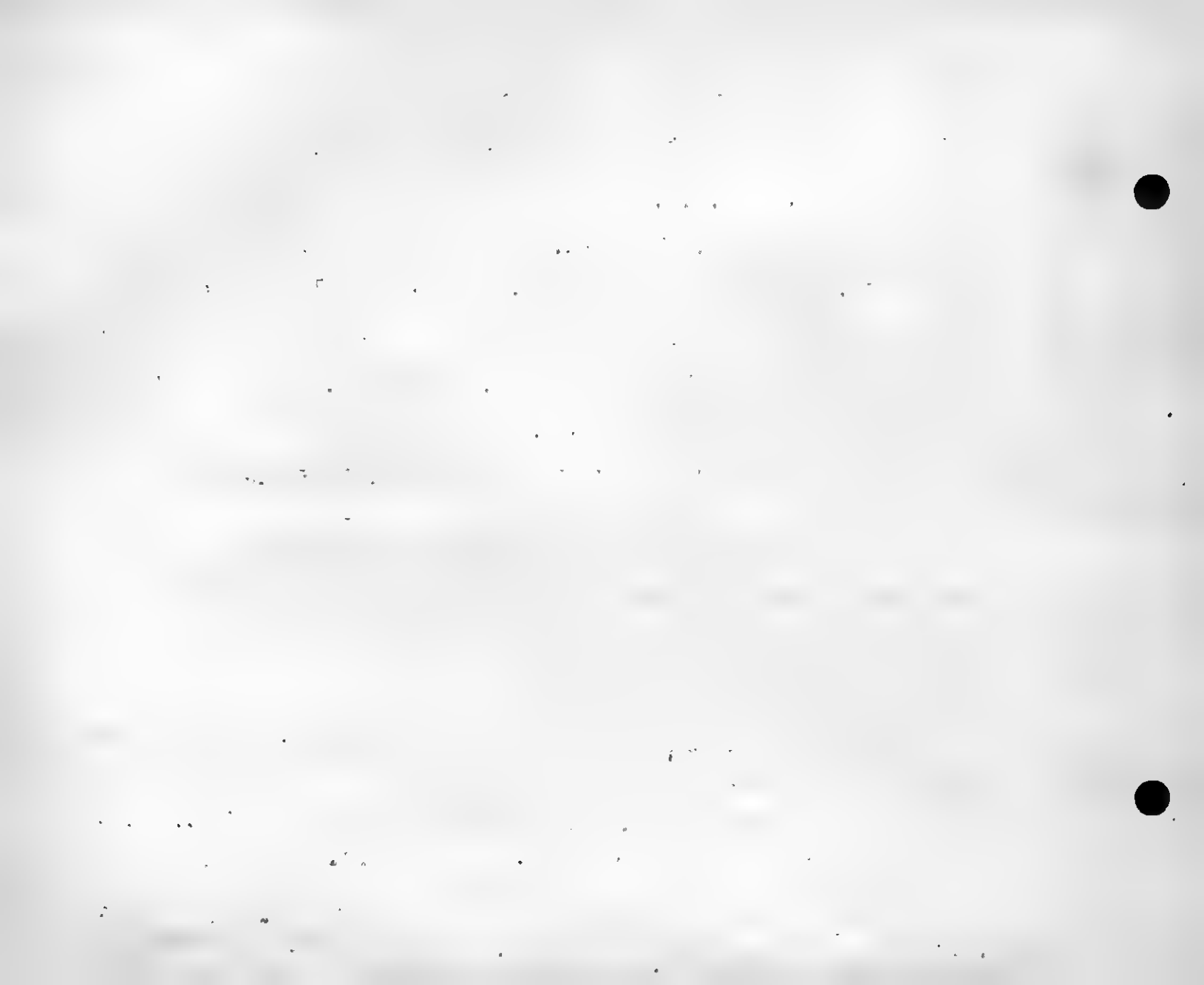
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1 DECEASED NAME (Type or Print)			First <b>EVE</b>			Middle <b>WOLFF</b>			Last <b>WOLFF</b>			2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> ESTI MATED <input type="checkbox"/> <b>12</b> Day <b>7</b> Year <b>1968</b>			2b HOUR <b>11:50</b> A M				
3 SEX <b>Female</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>Mar 1, 1885</b>		6 AGE (in years last birthday) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD Month <b>Dec</b> Day <b>7</b> Year <b>1968</b>			2d HOUR <b>11:50</b> A M				
7a BIRTHPLACE (State or foreign country) <b>Poland</b>				7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				8 MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Baltimore</b>							
10 CITY OR TOWN OF DEATH <b>Pikesville</b>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>926 Milford Mill Rd.</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>				12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>				13b COUNTY <b>Balto.</b>				13c CITY OR TOWN <b>Pikesville</b>				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET AND NUMBER <b>926 Milford Mill Rd.</b>			
14. FATHER'S NAME First Middle Last <b>Ellenberg</b>						15 MOTHER'S MAIDEN NAME First Middle Last <b>Ellenberg</b>													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no.</b>						16b SOCIAL SECURITY NO (If yes give year or dates of service) <b>099-01-7188</b>						17 INFORMANT <b>Julius Wolff</b> ADDRESS <b>6738 Brogton Rd. Balt. 7</b>							
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic C-V. Disease</b> <b>4127</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4 none</b>																			
19a DATE OF OPERATION <b>9/20/65</b>						19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Abdominal adhesions</b>						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <b>none</b>						21b TIME OF INJURY Month, Day Year HO. R A M P M <b>none.</b>						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>none.</b>							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>none.</b>						21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>D.D. Caples</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b DATE SIGNED <b>12-7-68</b>							
EXAMINER'S NAME (Type) <b>D.D. CAPLES M.D.</b>						ASS STANT MED. CA. EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ADDRESS (Street, city, town, or county)						ADDRESS (Street, city, town, or county)													
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				23b DATE <b>12/4/68</b>				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State) <b>New York, N. Y.</b>							
24 FUNERAL DIRECTOR <b>Wm. J. Techner</b>						ADDRESS <b>Sonn. Balt. Md.</b>						25a REC'D BY REG-STRAR <b>DEC 10 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> <div> 17203  Item 13 Film 408 1/2/69 kk </div> <div> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div> <div> 17304 </div> </div>											
1. DECEASED-NAME (Type or print) <b>HENRY NMN WOODMAN</b>						2a. DATE OF DEATH <b>12</b> Month <b>23</b> Day <b>68</b> Year			2b. HOUR <b>6:55</b> MIN <b>A</b>		
3. SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 30, 1897</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Morrisville, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Gr. Balto. Med. Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <b>Retired-Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1030 1097 Woodson Road</b>			
14. FATHER'S NAME First <b>Isaac</b> Middle <b>Woodman</b> Last <b>Blaker</b>				15. MOTHER'S MAIDEN NAME First <b>Mathilda</b> Middle <b>Blaker</b> Last <b>Blaker</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>145-20-0281</b>		17. INFORMANT Address <b>Mrs. Marjorie B. Woodman (Same)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>CEREBROVASCULAR ACCIDENT @ RESP. ARREST</b> (b) <b>ATRIAL FIBRILLATION @ A S H D</b> (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <b>12/18, 1968</b> to <b>12/23, 1968</b> , that (I) (we) lost the deceased on <b>12/23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Barry R. Friedlander MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>12/23/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>DR. BARRY FRIEDLANDER MD.</b>						22e. ADDRESS <b>6701 N. CHARLES ST.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>12/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>					
24. FUNERAL DIRECTOR <b>I.W. Jenkins</b>		25. DATE <b>12/23/68</b>		25a. RECEIVED BY REGISTRAR <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					
30A REV 1/68		BALTO. 12, MD.		4905 York Rd.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers (pages 4 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

17294

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17305

1. DECEASED NAME (Type or print) <i>John M. Woodward</i>			2a. DATE OF DEATH Month <i>12</i> Day <i>27</i> Year <i>1968</i>			2b. HOUR <i>6:15</i> M								
3. SEX <i>MALE</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>7/29/1891</i>		6. AGE (In years last birthday) <i>77</i> YRS.		7. UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>10</i>		8. UNDER 24 HRS. HOURS <i>1</i> MIN <i>15</i>				
7a. BIRTHPLACE (State or foreign country) <i>N.C.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i> Md.					
10. CITY OR TOWN OF DEATH <i>Catoonsville, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Spring Grove State Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Chaucer Co.</i>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>330 Rivernew Rd.</i>		
14. FATHER'S NAME First <i>John</i> Middle <i>R.</i> Last <i>R.</i>						15. MOTHER'S MAIDEN NAME First <i>Susan</i> Middle <i>Susan</i> Last <i>Susan</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>Yes, no, or unknown</i>				16b. SOCIAL SECURITY NO <i>216-05-5334</i>				17. INFORMANT <i>Fathy</i> Address <i>Susan</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>485 X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>491 X</i> (b) <i>Upper respiratory infection</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Traps</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic brain syndrome associated with cerebral arteriosclerosis</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>12/27</i> , 19 <i>68</i> , to <i>12/28</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d) (did not) view the body after death.														
22b. SIGNATURE <i>M. A. Lotfizadeh, M.D.</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>12-28-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>MOHAMMAD A. LOTFIZADEH</i>						22e. ADDRESS <i>Spring Grove State Hospital</i>								
23a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Crem</i>			23b. DATE <i>12-30-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Woodlands Cem</i>			23d. LOCATION (City or Town) (County) (State) <i>Elkridge Md</i>					
24. FUNERAL DIRECTOR <i>J. H. Hahn</i>						ADDRESS <i>Funeral Home, 4200 Pennsylvania Ave</i>			25a. REC'D BY REGISTRAR DATE <i>JAN 3 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION

17305  
JAN 3 1969





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A  
30M REV 1-68

17205

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17306

1. DECEASED NAME (Type or print) <b>ERED R. WOODWORTH</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>04</b> Year <b>68</b>			2b. HOUR <b>10P</b> MIN <b>5</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>01-05-01</b>		6. AGE (In years last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>MASS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GRTR. BALTO. MED. CNTR.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Pipe fitter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4216 MORRISON COURT</b>	
14. FATHER'S NAME First <b>Tites</b> Middle <b>Woodworth</b> Last <b>Woodworth</b>			15. MOTHER'S MAIDEN NAME First <b>Elfa</b> Middle <b>Seannell</b> Last <b>Seannell</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service) <b>WWI</b>			
16b. SOCIAL SECURITY NO <b>214-01-3991</b>			17. INFORMANT <b>Family</b>			Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>16.2 x</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <b>11-29</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTESTIONAL OBSTRUCTION</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-27</b> , 19 <b>68</b> , to <b>12-04</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-04-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Chang-i Lin</b>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-05-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. CHANG-I-LIN</b>				22e. ADDRESS <b>6701 N. CHARLES STREET</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-09-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Maryland</b>			
24. FUNERAL DIRECTOR <b>John H. Hahn Funeral Home, 4200 Pennsylvania Ave.</b>				25a. REC'D BY REGISTRAR <b>DEC 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR						
			Leon r		nmn		Wormser		12 Month 5 Day 68 Year		7 P M						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male			White			7-11-1904			64 YRS								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Md.			U.S.A.						Baltimore County					Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
Randallstown			Balto. Co. Gen. Hosp.			DEPT. SALES MAN			RETAIL								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
Md.			Balto.			Balto.			YES <input type="checkbox"/> NO <input type="checkbox"/>			7926 Dunhill Village					
14. FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME			First Middle Last		
Sigmond						Wormser						XXXXXXXXXXXXXANNA			?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
NO									MRS. IDA WORMSER,			7926 DUNHILL VILLAGE CIR.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>										<u>One Day</u>							
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardio. Vascular Disease</u>										<u>15 years</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Disease</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
411																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town			County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>December, 1968</u> , to <u>December, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Cecil Rudner MD</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>12-5-68</u>							
22d. PHYSICIAN'S NAME (Type) <u>CECIL RUDNER MD</u>										22e. ADDRESS <u>6821 Reisterstown Road, 21st</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
BURIAL			12-8-68			HEBREW YOUNG MEN			BALTIMORE, MARYLAND								
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u> ADDRESS										25a. REC'D BY REGISTRAR <u>DEC 10 1968</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

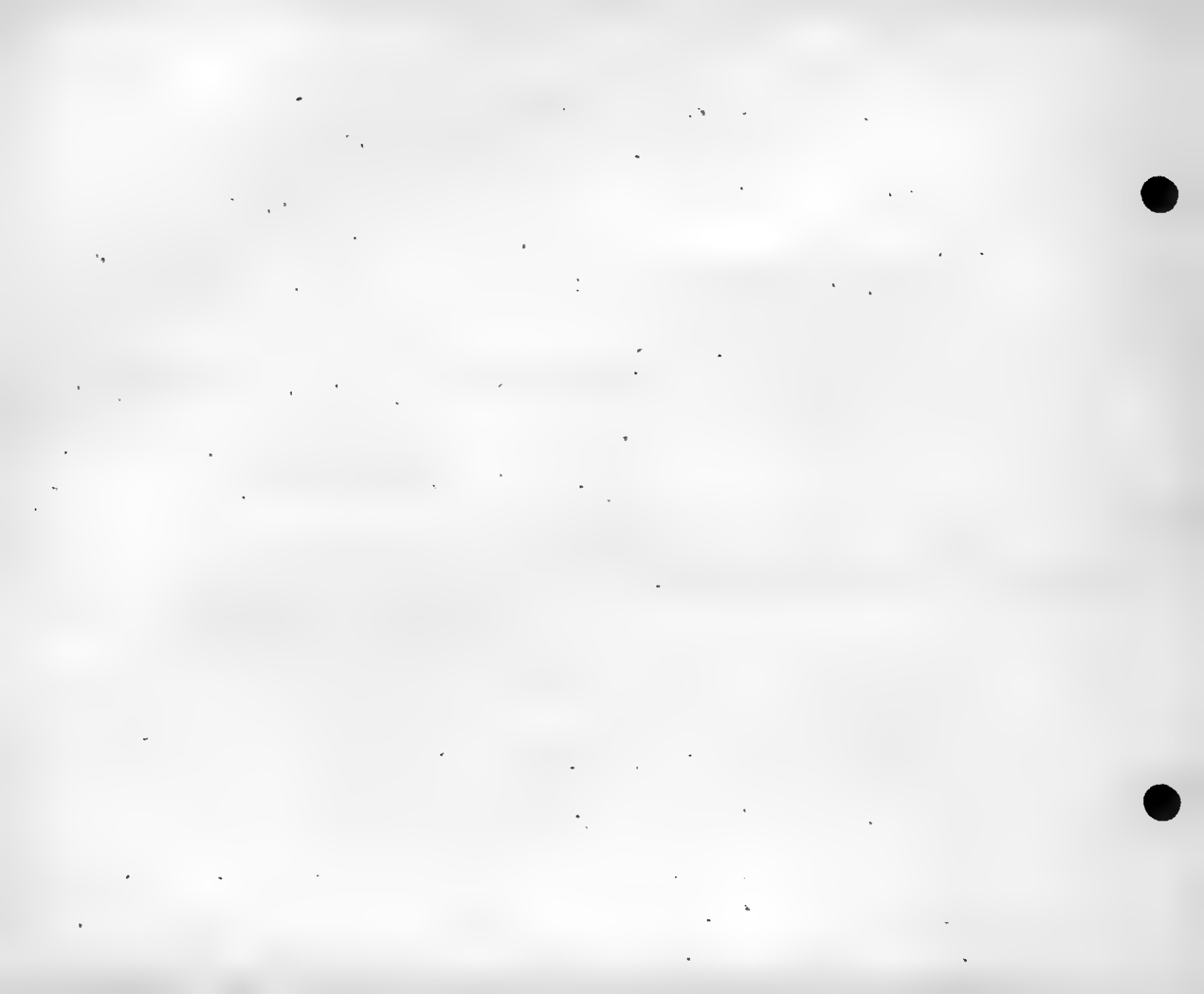
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17308

1 DECEASED-NAME (Type or print) First Middle Last <i>Corra Eva Wright</i>			2a. DATE OF DEATH Dec Month 12 Day 68 Year		2b. HOUR M
3 SEX <i>F</i>	4 RACE <i>Cauc.</i>	5 DATE OF BIRTH <i>Dec. 12, 1896</i>		6 AGE (In years last birthday) <i>72</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Balto -</i>		
10. CITY OR TOWN OF DEATH <i>White Hall</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Meredith Rd.</i>		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>White Hall</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Meredith Rd.</i>	
14 FATHER'S NAME First Middle Last <i>John T. Ensor</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Florence Bull</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) <i>NO</i>		16b. SOCIAL SECURITY NO <i>216-07-5565</i>		17 INFORMANT <i>Mrs. Beverly M. Corbett, Stewartstown, Pa.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary artery disease with occlusion.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis Heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>68 yrs.</i> Condit ions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:(a) <i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>June, 1965</i> , to <i>Nov</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>William O. Fulton MD</i>		22c. DATE SIGNED <i>Dec. 13, 1968</i>		22d. PHYSICIAN'S NAME (Type) <i>William O. Fulton, M.D.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12/15/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>West Liberty Cem.</i>	
24. FUNERAL DIRECTOR <i>James Hartenstein</i>		25a. REC'D BY REGISTRAR <i>DEC 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23b per tele. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 with FH 12/24/68 <b>17208</b> <b>CERTIFICATE OF DEATH</b> <b>17309</b>											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
FRANCIS CLOYD ZECKMAN						12 23 68			3:08M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		White		9-28-1890		78 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Penn.		USA				BALTIMORE Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		GR. BALTO. MED. CENTER		MAINTENANCE		AIR CRAFT					
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md		BALTO		Parkville				2706 Alden Rd			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Emanuel Zeckman			Lydia Boly								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			189-09-8790			Ida Zeckman			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMATOSIS											
1519 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF THE STOMACH											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
151X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
E. Hunter Wilson Jr MD						DEGREE		12-23-68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
E. HUNTER WILSON, JR. MD						803 MEDICAL ARTS. BLDG.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		12/26/68		Morchard Memorial		Baltimore Md					
24. FUNERAL DIRECTOR						ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Char F. Evans & Son						8801 Harford Rd		DATE DEC 24 1968		Charles Judge	





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17209

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17310

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
WILLIAM HENRY ZENDGRAFT						Month Day Year			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR		
male	white	May 16, 1909	59 YRS	MONTHS	DAYS	Month Day Year			M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
Maryland		U.S.A.				Baltimore			Randallstown		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before address in State)		
Balto. Co. Gen. Hosp.			Custodian			Balt. Co. School Board			Maryland		
13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Carroll			Westminster			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			289 E Main St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		
Albert			Mary			Yes			213-05-1186		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19. DATE OF OPERATION			20. AUTOPSY?		
Robert C. Zendgraft			PART 1. DEATH WAS CAUSED BY:			19 Dec 24 1968			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease								
			DUE TO, OR AS A CONSEQUENCE OF								
			(b)								
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
422											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			22a. I certify that I took charge of the remains described above, held an		
CAUSE OF DEATH			19						Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)			22e. REGISTRAR'S SIGNATURE		
12/21/68			Westminster Cemetery			Westminster Carroll Md.			f Charles Judge		
23a. BURIAL, CREMATION REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Dec. 24, 1968			Westminster Cemetery			Westminster Carroll Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE		
Thomas Dale Fletcher Funeral Home			254 E. Main St.			DEC 24 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17300												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												17311											
CERTIFICATE OF DEATH																																			
1. DECEASED-NAME (Type or print)						First Middle Last						2a. DATE OF DEATH						2b. HOUR																	
CHARLES						RAYMOND						ZEPP						DECEMBER 13, 1968						2:35 PM											
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR				IF UNDER 24 HRS.															
MALE				WHITE				7/2/98				70 YRS.				MONTHS				DAYS															
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																							
MARYLAND				U.S.A.								BALTIMORE																							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, or if retired)				12b. KIND OF BUSINESS OR INDUSTRY																							
FORT HOWARD				VETERANS ADMIN. HOSPITAL				STORE MANAGER																											
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER																			
MARYLAND				BALTIMORE				BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				303 CLYDE AVENUE																			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																													
First Middle Last						First Middle Last																													
HENRY - - ZEPP						CATHERINE - - MAHL																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)						16b. SOCIAL SECURITY NO.						17. INFORMANT																							
YES WWI						215 09 05 08						CLINICAL RECORDS, VAM, FT. HOWARD, MD.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART I. DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA												DAYS																							
1621 DUE TO, OR AS A CONSEQUENCE OF																																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b) CARCINOMA, LEFT LUNG																							
												DUE TO, OR AS A CONSEQUENCE OF																							
												(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																			
163X																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (X) (this hospital) attended the deceased from NOV 5, 1968, to DEC 13, 1968, that (X) (we) last saw the deceased alive on DEC 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE												22c. DATE SIGNED																							
MARIO J. QUIROS, M.D.												12/14/68																							
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS																							
MARIO J. QUIROS, M.D.												VAM, FT. HOWARD, MD.																							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)																							
BURIAL				12/17/68				MEADOWEDGE MEMORIAL PARK WASHINGTON BLVD, DORSEY, MD.																											
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR																							
JOSEPH AMBROSE FUNERAL HOME ARBUTUS, MD.												25b. REGISTRAR'S SIGNATURE																							
												DEC 16 1968																							

1-11-11

RECEIVED JAN 11 1911

TO THE DIRECTOR  
BUREAU OF LANDS  
WASHINGTON, D.C.

FROM THE  
SPECIAL AGENT IN CHARGE  
OF THE LANDS

RE: [illegible]

THE [illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible]

[illegible]

DATE: [illegible]

BY: [illegible]

JOHN AMMONS TOWNSEND, JR.  
1909  
WASHINGTON MEMORIAL PARK  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Ernest Oliver ZIMMERMAN, Sr.						12 Month 29 Day 68 Year		2:45 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Cau		6/6/03		65 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		USA				Baltimore		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson			Greater Balto. Med. Center							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		Timonium				106 Springside Dr.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Frederick Ernest Zimmerman			Caroline E. Murray							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			705-10-9450		Ernest O. Zimmerman, 2031 Reuter Rd. Lutherville					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Arteriosclerotic cardiovascular disease</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>4109</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
<u>Carcinoma of the esophagus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>68</u> , to <u>12/29</u> , 19 <u>68</u> , that (I) (we) lost the deceased on <u>12/29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
<u>Charles C. Brown, M.D.</u>						12/30/68				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Charles C. Brown, M.D.						6701 N. Charles Street				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		XXX 12-1969		Glen Haven Mem. Park		Glen Burnie, Md.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks Towson 1050 York Rd. Towson						JAN 3 1969		<u>Charles Judge</u>		

*[Faint, illegible text at the bottom of the page]*